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Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

JANE TOMCZYK,

Petitioner,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. May the courts grant and affirm summary judgment as a matter of law when the affidavits are in conflict and raise genuine issues of fact and shift the burden of proof to the non-moving party.

2. Does ERISA provide a distinction between insured and self-insured employee benefit plans and may a state regulate the insurer and its insurance contracts, particularly if the state law applies only to the insurance business.

TABLE OF CONTENTS

	PAGE
QUESTIONS PRESENTED	i
TABLE OF CONTENTS	ii
INDEX TO APPENDIX	iii
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	2
JURISDICTION	2
STATUTES INVOLVED	2
STATEMENT OF THE CASE	4
REASONS FOR GRANTING THE WRIT	9
A. SUMMARY JUDGMENT DISPOSITION OF ERISA CLAIM WAS IMPROPER	9
B. THE DISMISSAL OF STATE LAW REMEDIES THAT PURPORT TO REGULATE THE INSURER HEREIN	11
C. CASTIGATION OF TOMCZYK COUNSEL AND IMPOSITION OF SANCTIONS	17
LIMITED RESPONSE AND CONCLUSION	20

INDEX TO APPENDIX

	APP. PAGE
Opinion of the United States Court of Appeals for the Seventh Circuit, December 30, 1991 ...	1
Judgment of the United States Court of Appeals for the Seventh Circuit, December 30, 1991 ..	17
Decision and Order of the United States District Court, Eastern District of Wisconsin, December 6, 1990	18
Decision and Order of the United States District Court, Eastern District of Wisconsin, May 8, 1989	30
Pertinent Pages of Appellant's Brief in the United States Court of Appeal for the Seventh Circuit ..	39
Pertinent Pages of the Appellant's Reply Brief in the United States Court of Appeal for the Seventh Circuit	41
Affidavit of John A. Goeckerman, D.D.S.	44
Explanation of Benefits by Blue Cross	48
Affidavit of Elise McKinch, R.N., B.S.	49
"Federal court penalizes law firm $2,000 for frivolous appeal", The Milwaukee Sentinel, January 3, 1992	51

TABLE OF AUTHORITIES

Cases	PAGE
Anderson v. Continental Ins. Co., 271 N.W.2d 368, 85 Wis. 2d 675 (1978)	7, 11, 12, 13
Benke v. Mukwonago-Vernon Mut'l Ins. Co., 329 N.W.2d 243, 110 Wis. 2d 356 (1982)	13
Cedar Rapids Pediatric Clinic Pension Plan v. Continental Ins. Co., 690 F. Supp. 792 (W.D. Ark. 1988)	21
Davis v. Allstate, 303 N.W.2d 596, 101 Wis. 2d 1 (1981)	13
Dvorak v. Pluswood, Wis. Ins., 358 N.W.2d 544, 121 Wis. 2d 218 (1984)	13
FMC Corp. v. Holliday, 111 S.Ct. 403 (1990)	14
Gruenberg v. Aetna Ins. Co., 9 Cal. 3d 566, 108 Cal. Rptr. 480, 510 P.2d 1032 (1973)	13
Hilker v. Western Auto. Ins. Co., 235 N.W. 413, 204 Wis. 1 (1931)	12, 13
Indianapolis Colts v. Mayor of Baltimore, 775 F.2d 177 (7th Cir. 1985)	19
Kranzush v. Badger State Mut'l Cas. Co., 307 N.W.2d 256, 103 Wis. 2d 56 (1981)	13
Maciosek v. Blue Cross and Blue Shield United of Wisconsin, 930 F.2d 536 (7th Cir. 1991)	18
Mays v. Chicago Sun Times, 865 F.2d 134 (7th Cir. 1989)	19
Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380 (1985)	15, 16
Moutoux v. Gulling Auto Elec., Inc., 295 F.2d 573 (7th Cir. 1971)	9

Pilot Life v. Dedeaux, 481 U.S. 41 (1987) 7, 11, 20, 21

Poling v. WPS, 357 N.W.2d 293, 120 Wis. 2d 603 (1984) 13

Reilly v. Blue Cross and Blue Shield United of Wisconsin, 846 F.2d 416 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988) 16

Smith v. Blue Cross & Blue Shield United of Wisconsin, 724 F. Supp. 618 (E.D. Wis. 1989) ... 21

Tomczyk v. Blue Cross and Blue Shield United of Wisconsin, Case No.: 91-1018 (7th Cir.) 2

Statutes

28 U.S.C. Sec. 1291 4

28 U.S.C. Sec. 2101(c) 2

29 U.S.C. Sec. 1132 4

29 U.S.C. Sec. 1132(a)(3) 2

29 U.S.C. Sec. 1144(a) 3

29 U.S.C. Sec. 1144(a)(3) 3

29 U.S.C. Sec. 1144(b)(2)(A) 3

29 U.S.C. Sec. 1144(b)(2)(B) 3

Fed. R. Civ. P. 56(c) 9

Other

Wis. JI-Civil 2760 14

Wis. JI-Civil 2761 14

Wis. JI-Civil 2762 14

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Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioner, Jane Tomczyk, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit affirming the District Court for the Eastern District of Wisconsin granting of summary judgment to Blue Cross on ERISA claims and dismissing all other claims dealing with state law regulation of an insurance company, insuring an employee benefit plan.

OPINIONS BELOW

The judgment in *Tomczyk v. Blue Cross and Blue Shield United of Wisconsin*,[1] Case No.: 91-1018 (7th Cir.) was decided and entered on December 30, 1991.

The decisions and orders of the United States District Court for the Eastern District of Wisconsin dated May 8, 1989 and December 6, 1990.

JURISDICTION

The United States Supreme Court has jurisdiction to review the judgment in question hereby by writ of certiorari pursuant to 28 U.S.C. Sec. 2101(c).

STATUTES INVOLVED

This case involved the following statutory provisions: Sec. 514(a), 29 U.S.C. Sec. 1144(a); Sec. 514(b)(2)(A), 29 U.S.C. Sec. 1144(b)(2)(A); Sec. 502(a)(3), 29 U.S.C. Sec. 1144(a)(3); and 29 U.S.C. Sec. 1132(a)(3).

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[1] *Jane Tomczyk v. Blue Cross and Blue Shield United of Wisconsin*, United States Court of Appeals for the Seventh Circuit, Case No. 91-1018, by the Honorable Richard A. Posner, the Honorable Joel M. Flaum and the Honorable Michael S. Kanne. Per Curiam.

Sec. 514(a), 29 U.S.C. Sec. 1144(a) (pre-emption clause) states in pertinent part:

> "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."

Sec. 514(b)(2)(A), 29 U.S.C. Sec. 1144(b)(2)(A) (savings clause) states:

> "Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

Sec. 514(b)(2)(B), 29 U.S.C. Sec. 1144(b)(2)(B) (deemer clause) states:

> "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

Lastly, Sec. 502(a)(3), 29 U.S.C. Sec. 1144(a)(3) provides:

> "A civil action may be brought:
>
> (3) By a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan or (B) to obtain other appropriate relief (i) to redress such violations or (ii) to enforce any provisions of the subchapter or terms of the plan;"

STATEMENT OF THE CASE

This case was originally filed on June 29, 1988 in the United States District Court for the Eastern District of Wisconsin, Case Number 88-C-690. The District Court had original jurisdiction in this matter pursuant to 29 U.S.C. Sec. 1132 and also had jurisdiction over pendent state laws that regulate the business of insurance.

On May 8, 1989, the District Court, by the Honorable Robert W. Warren, by order granted the defendant-appellee's motion for summary judgment dismissing Jane Tomczyk's state law claims. (App. 30). The court requested supplemental briefs on summary judgment in regards to Jane Tomczyk's claim for ERISA benefits.

On December 6, 1990, the District Court dismissed the plaintiff's remaining ERISA claims for benefits. (App. 18).

Jane Tomczyk appealed the judgments of May 8, 1989 and December 6, 1990 to the United States Court of Appeals for the Seventh Circuit pursuant to 28 U.S.C. Sec. 1291.

The Appellate Court issued its Per Curiam decision and judgment on December 30, 1991 and it was received by Kmiec Law Offices on January 2, 1992. (App. 1 and 17). The Court of Appeals affirmed the District Court in all respects and imposed Rule 38 sanctions on the appellant's attorneys, Marjan R. Kmiec and Christopher A. McConville of Kmiec Law Offices, ". . . because of the largely frivolous nature of this appeal, as well as the misleading manner in which it was presented to this Court, ..." (App. 1).

The Court of Appeals found that there were no genuine issues as to any material facts and entered summary judgment as a matter of law based on the affidavits and the defendant's motion for summary judgment.

The Appellate Court, in its opinion, disagreed with Tomczyk that her affidavit by Dr. Goeckerman raised an issue of fact regarding pre-authorization of her hospital and medical bills by Blue Cross. The court did accept the affidavit of McKinch, R.N., employee of Blue Cross, to the effect that Blue Cross "would authorize a three (3) day inpatient hospital stay" as merely an indication that "the authorization related to the patient's need to have the procedures done as an inpatient and was not an authorization of coverage."

Attorney McConville was categorized by the Court as falsely asserting that Dr. Goeckerman "thought he had authority not only for the hospital stay, but for the surgery" on the basis that Dr. Goeckerman sent a letter to Blue Cross on October 7, 1987—four (4) days after the surgery—with the first sentence reading "this letter is sent as a request for prior determination of benefits."

The Court stated that the doctor's letter shows he knew Blue Cross had not pre-authorized the surgery that had already taken place on October 3, 1987.

The Court concluded as a matter of law that Attorney McConville had manipulated facts and found that no material facts existed as to whether the surgical treatment was, in fact, authorized.

The Court also concluded that although there was no dispute that the hospital stay was pre-authorized, it does not necessarily result in reimbursement. The pre-authorization somehow only related to the need to have the pro-

cedure done as an inpatient but did not, in fact, authorize coverage.

The Court of Appeals further admonished Attorney McConville to the effect that he perpetuated these blatantly inaccurate characterizations at oral argument. The Court was referring to Attorney McConville's oral argument in reference to the affidavits and the letter of Dr. Goeckerman. The Court remarked that Attorney McConville's oral argument in said respect, "highlight his generally distressing approach in this appeal." (App. 5).

The Court concluded that the plaintiff must set forth specific facts showing a genuine issue of material fact which requires trial, which the plaintiff had not done.

The District Court on the motion for summary judgment had bifurcated the causes of action dealing with state court remedies and ERISA benefits. The District Court judgment dismissing the cause of action in respect to state law regulations was filed on May 8, 1989 and the Court then granted its summary judgment in respect to ERISA benefits on December 6, 1990. (App. 30 and 18).

The Court of Appeals in its decision subsequent to affirming the summary judgment on the merits of the case dealing with ERISA benefits continued in its decision to review the summary judgment in respect to state court remedies.

The Court of Appeals found that Tomczyk was attempting to circumvent ERISA's broad pre-emption through the use of the savings clause and tried to salvage the breach of contract and related state law claims as federal law claims based on a breach of fiduciary duty under ERISA. (App. 7).

The Court found that the parties do not dispute the fact that the plan is, in fact, insured.

The Court further concluded that Tomczyk, in trying to distinguish Mississippi punitive damage law in *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987) and Wisconsin bad faith law application to insurance regulation had attempted to mislead the Court of Appeals, which was commonplace in this appeal. That Tomczyk ignores the clear mandate of Supreme Court precedent. (App. 7-8).

The Court used Tomczyk's citation of *Anderson v. Continental Ins. Co.*, 85 Wis. 2d 675, 271 N.W.2d 368 (1978), to the effect that indeed *Anderson* not only did not limit bad faith law to the insurance industry, but stated to the contrary that "every contract imposes upon each party a duty of good faith and fair dealing in its performance and enforcement." *Anderson* at 375.

The Court felt that Tomczyk's reliance upon *Anderson* was an attempt to mislead the Court of Appeals.

The Court stated that Tomczyk was attempting to add a new twist in asking the court to consider state common law claims as claims for breach of fiduciary duty under ERISA and that it was an "ostrich like" attempt by Tomczyk's counsel to avoid existing authority in an unprofessional and pointless manner. (App. 10).

The Court of Appeals concluded that Tomczyk's counsel, Christopher A. McConville and Marjan R. Kmiec, both of Kmiec Law Offices, continued a disturbing pattern of litigating claims that repeatedly advanced the same frivolous arguments. (App. 10).

The Court stated that an appeal is frivolous when the result is obvious or when the appellant's argument is wholly without merit. (App. 14). The Court concluded that

there were no colorable basis in law for the litigant's position.

The Court then concluded that Tomczyk ignored, glossed over or misstated the law. That puffery was proffered as fact and that the attorneys presented the record in a thoroughly misleading and unprofessional fashion, thereby demonstrating frivolousness. The entire manner in which this appeal had been pursued justified sanctions. (App. 15). The Court then imposed a significant penalty against Tomczyk's attorneys in the amount of $2,000.00 and further assessed the costs of the appeal upon counsel in the amount of $688.94.

The plaintiff, Jane Tomczyk, and her counsel, Marjan R. Kmiec, petition this court for a writ of certiorari regarding the summary judgment dismissal of the ERISA claims, the dismissal of state laws that regulate insurers and insurance contracts, the imposition of sanctions and costs of appeal and the castigation of Tomczyk's counsel with the hopeful restitution of their reputation.

REASONS FOR GRANTING THE WRIT

A.

SUMMARY JUDGEMENT DISPOSITION OF ERISA CLAIM WAS IMPROPER.

Christopher McConville, the attorney who briefed this case and appeared at the oral argument before the Court of Appeals, is no longer with Kmiec Law Offices. The petitioner's counsel herein, Marjan R. Kmiec, hastily points out that he has respect for the integrity and honesty of Attorney McConville, particularly in his judicial representations.

It is incumbent upon the moving party to show that there are no material facts in dispute and if there is any doubt concerning the existence or non-existence of a material fact, that doubt or reasonable inference must be resolved against the moving party and summary judgment will not be granted. Fed. R. Civ. P. 56(c). *Moutoux v. Gulling Auto Elec., Inc.*, 295 F.2d 573, 577 (7th Cir. 1971).

It is Tomczyk's position that the Court of Appeals in affirming the District Court's summary judgment order violated the legal standards for deciding summary judgment motions as set out in Fed. R. Civ. P. 56(c) and decisions of the Seventh Circuit Court of Appeals. The Court (at App. 5) indicated it was disturbed by the manner in which counsel for Tomczyk manipulated relevant facts.

The fact is that the record shows unequivocally that the purpose for contacting Blue Cross on September 30, 1987 was to obtain the pre-authorization for the plaintiff's surgery and that a representative of Blue Cross stated that the plaintiff's insurance had authorized the hospital stay *for the intended surgery*. (App. 44).

The Court of Appeals stated that McConville had falsely asserted to the court that Goeckerman thought he had authority for the hospital stay and the surgery, particularly because the October 7, 1987 letter was a request for prior determination of benefits in respect to surgery that had already been performed on October 3, 1987.

The fact is that the surgery had not been performed on October 3, 1987, but rather was performed on October 21, 1987 and October 27, 1987. (App. 48).

The Court of Appeals refers to the affidavit of Dr. Goeckerman only in the context that the hospital stay was pre-authorized but the court would not infer that the hospital stay and surgery were pre-authorized in spite of Dr. Goeckerman's affidavit that the purpose of the contact with Blue Cross was to obtain pre-authorization of the plaintiff's surgery and that ". . . Blue Cross stated that the plaintiff's insurance had authorized the hospital stay for the intended surgery." (App. 44).

The Court made no reference to paragraph four (4) of Dr. Goeckerman's affidavit to the effect that on June 8 or June 9, 1988 he had received a telephone call from a representative of Blue Cross indicating that it was not specifically stated in the policy that it was not a covered benefit but that Blue Cross simply would not pay the claim. (App. 45).

While Blue Cross does not dispute that they had authorized a hospital stay for the intended surgery, the Court of Appeals found that the authorization for the inpatient hospital stay was simply an indication that the procedure needed to be done as an inpatient but with no authority for coverage.

It is incongruous that Blue Cross would have a pre-authorization procedure that would authorize a three (3)

day inpatient hospital stay for surgery that it would not authorize.

In conclusion, the affidavits submitted on summary judgment regarding the ERISA claim itself can be interpreted as the reader chooses. Tomczyk submits that the legal standards for deciding summary judgment motions were not applied and, if anything, doubt or reasonable inferences were resolved against the non-moving party, contrary to law. A trial by affidavit is unfair and adds but another burden to recoveries under ERISA.

B.

THE DISMISSAL OF STATE LAW REMEDIES THAT PURPORT TO REGULATE THE INSURER HEREIN.

Blue Cross is an insurance company. The employee benefit plan herein is insured. This is conceded by both parties and the Court of Appeals. The employer is not a party to the action and the action involves only the insurer.

It is suggested that the Court of Appeals may have declined to proceed any further with this case following the dismissal of the case on the merits in respect to the ERISA claim. The court did, however, continue with the resulting imposition of sanctions against Tomczyk's counsel.

Tomczyk attempted to distinguish Mississippi bad faith law cited in *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987) with Wisconsin bad faith law which applies only to the insurance industry. The Court of Appeals took issue with Tomczyk's contention by stating that the case of *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 85 Wis. 2d 675 (1978) indeed stated to the contrary—that "every *contract* imposes upon each party a duty of good faith and fair

dealing in its performance and its enforcement." *Anderson*, 271 N.W.2d at 375, 85 Wis. 2d at 689. (Quoting, Restatement, Law of Contracts, sec. 231, 2d, (1973). (Emphasis added).

In due deference to the Court of Appeals, the Court's citation of a partial sentence from *Anderson* to the effect that Wisconsin bad faith law has general application to contracts is totally misplaced and undermines the Court of Appeal's decision.

It is an abuse of Tomczyk's counsel for the Court to conclude that attempts such as this to mislead the Court were unfortunately a commonplace in this appeal. (App. 8).

Tomczyk's counsel has been involved in a number of Wisconsin state court bad faith lawsuits. Counsel does not attempt to deceive or mislead any court with its position that the common law concept of bad faith has been applied in Wisconsin only in cases involving the insurance industry and insurance contracts.

Anderson is a bad faith insurance case. *Anderson*, after stating that bad faith is not a tortious breach of contract but a separate intentional wrong resulting from a breach of duty, imposed as a consequence of the relationship established by contract, 271 N.W.2d at 374, 85 Wis. 2d at 687, adds at the following page that "this duty is implied as a correlative duty growing out of certain rights and privileges which the contract confers upon the insurer." *Anderson*, 271 N.W.2d at 375, quoting, *Hilker v. Western Auto. Ins. Co.*, 235 N.W. 413, 414, 204 Wis. 1, 13 (1931).

The *Anderson* court predicates its bad faith rationale upon *Hilker v. Western Automobile Ins. Co.*, 231 N.W. 257, 235 N.W. 413, 204 Wis. 1 (1930, 1931). The court in *Hilker* found that Hilker's rights could not be predicated

on any policy provision, but that all courts agreed that the insurer owes to the insured, some duty in this respect.

Anderson cited the California case of *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 108 Cal. Rptr. 480, 510 P.2d 1032 (1973) to the effect that "it is manifest that a common legal principal underlies all of the foregoing decisions; namely, that in every insurance contract there is an implied covenant of good faith and fair dealing . . . accordingly, when the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort." *Anderson*, 271 N.W.2d at 375.

The Wisconsin court stated *Gruenberg* applied the principal of law set forth by the Wisconsin court in *Hilker* in 1930. *Anderson*, 271 N.W.2d at 376. The Wisconsin court accepted the bad faith principles of *Gruenberg* "to be applicable to first party claims which may be asserted in Wisconsin against insurance companies." *Anderson*, 271 N.W.2d at 376.

The Wisconsin Supreme Court and Appellate Courts have applied bad faith principles to insurance contracts in all of the following cases: *Davis v. Allstate*, 303 N.W.2d 596, 101 Wis. 2d 1 (1981); *Kranzush v. Badger State Mut'l Cas. Co.*, 307 N.W.2d 256, 103 Wis. 2d 56 (1981); *Benke v. Mukwonago-Vernon Mut'l Ins. Co.*, 329 N.W.2d 243, 110 Wis. 2d 356 (1982); *Poling v. WPS*, 357 N.W.2d 293, 120 Wis. 2d 603 (1984) and *Dvorak v. Pluswood, Wis. Ins.*, 358 N.W.2d 544, 121 Wis. 2d 218, 220 (1984), to the effect that "*Anderson* did recognize a separate tort action for bad faith breach of an *insurance* contract. . . ." 358 N.W.2d at 546, 121 Wis. 2d 218. (emphasis added).

Dvorak also held that a breach of an implied public policy provision in an employment contract creates a con-

tract action and not a tort action. 358 N.W.2d at 546, 121 Wis. 2d at 220.

Finally, Wisconsin Jury Instructions 2760, 2761 and 2762, are the only Wisconsin Jury Instructions that deal with bad faith and their exclusive application relates to the insurance industry and insurance contracts.

The Supreme Court has made its most definitive pronouncement in respect to the distinction between insured and uninsured plans in the context of state regulation of insurers and insurance contracts in the case of *FMC Corp. v. Holliday*, 111 S.Ct. 403 (1990). The Court set forth meticulously the various provisions of ERISA, 29 U.S.C. Sec. 1144(a), dealing with pre-emption, the savings clause and the deemer clause. *FMC*, at 407. This writer has adopted said citations and sets them forth in this petition under the title "STATUTES INVOLVED".

Significantly, the Supreme Court stated that said provisions are not a model of legislation. *FMC*, at 407.

The court in *FMC* found that a Pennsylvania anti-subrogation law was excluded from the reach of the savings clause because the deemer clause does not exempt self-funded ERISA plans from state laws that regulate insurance within the meaning of the savings clause. *FMC*, at 409. The court concluded that self-funded employee benefit plans are exempt from state regulations in so far as that regulation "relates to" the plans. *FMC*, at 409.

Importantly, the Supreme Court stated that on the other hand, employee benefit plans that are insured are subject to indirect state insurance regulations. An insurance company that insures a plan remains an insurance company for purposes of state laws purporting to regulate insurance. *FMC*, at 409.

It is obvious that even after application of the deemer clause, an insurance company remains an insurance company and is subject to state laws. Insurance companies obviously do not fall under some sort of protective mantel of an ERISA limitation of remedies. Rather it is employee benefit plans which ERISA controls.

The court made reference to its decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985) indicating that state statutes as applied to insurers of the plan were not pre-empted because they regulated insurance and were, therefore, saved. The Supreme Court acknowledged that their decision resulted in a "distinction between insured and uninsured plans, leaving (insured) plans open to indirect regulation and (uninsured) plans not." *Metropolitan*, 471 U.S. at 747. The *FMC* court further stated that Congress did not intend to pre-empt areas of traditional state regulation and there was a recognized distinction between insurers of plans and the contracts of those insurers which are subject to direct state regulation and self-insured employee benefit plans governed by ERISA, which are not. The court concluded that it observed Congress' presumed desire to reserve to the states the regulation of the "business of insurance." 111 S.Ct. at 410.

The court emphasized that the savings clause protects state regulation of insurance contracts purchased by employee benefit plans. *FMC*, 111 S.Ct. at 411.

The key conclusion of the court was "our interpretation of the deemer clause makes clear that if a plan is insured, a state may regulate it *indirectly* through *regulation of its insurer* and its insurer's insurance contracts; if the plan is uninsured the state may not regulate it." *FMC*, 111 S.Ct. at 411.

Justice Stevens in his dissent would go further. He felt the pre-emption clause was read to broadly by the majority and should apply only to state laws that purport to regulate subjects regulated by ERISA that are inconsistent with ERISA's central purpose.

It is interesting to note that the Tomczyk court made a footnote reference only to *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416, 418 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988), for the proposition that the court had therein definitively held that punitive damages are not available under ERISA. Circuit Judge Posner was a member of the *Reilly* court and is, of course, a member of the Tomczyk court. Judge Posner dissented with the majority in *Reilly*.

The majority in *Reilly* found that if a plan purchases insurance, as opposed to being self-insured, it is "directly affected by state laws that regulate the insurance industry." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). The *Reilly* court concluded that "we need not decide whether Wisconsin law concerning punitive damages and bad faith regulates insurance." 846 F.2d at 425. The reason being that the court found the plan in *Reilly* was self-insured. *Id.* The *Reilly* decision has never been overturned.

Judge Posner, in his *Reilly* dissent, indicated that "the denial of benefits may be right or wrong but it is a reasonable interpretation of the plan, and that should be the end of the case." 846 F.2d at 427. Judge Posner found that Judge Will, who wrote the majority opinion, disregarded the court's role in the proceeding, the nature of the proceeding, the standard of review and the burden of proof, but he has gone beyond the issues framed by the parties. *Id.*

C.

CASTIGATION OF TOMCZYK COUNSEL AND IMPOSITION OF SANCTIONS.

The court states that Attorney McConville's contention that Dr. Goeckerman thought he had authority not only for the hospital stay but for the surgery was a false contention by McConville because Dr. Goeckerman was indeed aware that Blue Cross had not pre-authorized the surgery in a letter dated October 7, 1987 in that he had already performed the surgery on October 3, 1987. The fact is that the surgery was not performed on October 3, 1987 as indicated in the court's decision, but rather on October 21, 1987 and October 27, 1987. (App. 48).

The Court went on to indicate that it was disturbed by the manner in which counsel for Tomczyk manipulated relevant facts.

That Tomczyk's brief reads into Goeckerman's affidavit statement that simply are not there. That Tomczyk's brief misrepresents the context of Dr. Goeckerman's letter of October 7, 1987. (App. 46-47). That Tomczyk's attorney perpetuated these blatantly inaccurate characterizations at oral argument and that only served to highlight his generally distressing approach in this appeal.

The court states that Tomczyk ignored the clear mandate of Supreme Court precedent, misstates the holdings of cases she cited in support of her position and fails to cite relevant cases from within this circuit.

The court stated that counsel's attempts to distinguish Mississippi bad faith law from that of Wisconsin was an attempt to mislead this court which were unfortunately and commonplace in this appeal. (App. 8).

The court claims that counsel failed to cite district court opinions in respect to cases that were pending on appeal and that it gave short shrift to the *Maciosek v. Blue Cross and Blue Shield United of Wisconsin*, 930 F.2d 536 (7th Cir. 1991).

The Court categorizes counsel's arguments as once more relying on the savings clause where this court previously rejected the attempt to circumvent the clear pre-emptive mandate of ERISA.

The Court accused counsel of adding twists in asking this court to consider state common law claims as claims for breach of fiduciary duty under ERISA. The court categorized Tomczyk's ostrich like attempts as being unprofessional and pointless.

The Court rejected Tomczyk's efforts to bootstrap state common law claims onto the ERISA claim. The court indicated that all said claims were pre-empted by ERISA.

The Court stated that counsel had refused to acknowledge the unfavorable holding in *Maciosek* until they were forced to address *Maciosek* following its prominent mention by Blue Cross.

The Court indicated that counsel employed a tactic of ignoring existing and potentially dispositive precedent as well as making numerous attempts to mislead this court through bold misrepresentations of fact and law and that it was a disservice to the parties, opposing counsel and this court.

Before leveling sanctions, the Court indicated that it wished to make clear that it was not its intent to "chill" discussion or to dissuade counsel from bringing credible appeals. The Court did not want to make itself a variable "mine field" for litigants as they determine whether to

pursue appeals. The Court indicated it only wanted a honest presentation of the case, adherence to the basic technical rules and a colorable basis in law and fact—as well as a certain amount of common sense and attorneys will thereby be shielded from sanctions.

The Court then cited that "an appeal is frivolous when the result is obvious or when the appellant's argument is wholly without merit." *Mays v. Chicago Sun Times*, 865 F.2d 134, 138 (7th Cir. 1989) (quoting, *Indianapolis Colts v. Mayor of Baltimore*, 775 F.2d 177, 184 (7th Cir. 1985)).

The Court continued with this tenure of comment about Tomczyk counsel for the balance of the decision.

The decision and comments of the Court in castigating Tomczyk counsel was prominently reported in the Milwaukee Journal, which has a state wide distribution. (App. 51). The Wisconsin Board of Attorney Professional Responsibility is currently investigating Attorneys Kmiec and McConville because of the sanctions imposed by the Tomczyk court.

LIMITED RESPONSE AND CONCLUSION

Tomczyk and her counsel implore the Supreme Court to allow it to fully address the summary judgment disposition of Tomczyk as a matter of law by the Court of Appeals and the District Court. Tomczyk believes its ERISA claims were tried on affidavits and is error as a matter of law.

We ask the court to allow Tomczyk to address the complexity of ERISA's pre-emption, savings and deemer clauses, particularly as to their early development and subsequent use by insurance companies as a defense to suits involving allegations of state court remedies.

We would like to address the ongoing dynamics of ERISA remedies. In this context, the Supreme Court indicated that "it is also intended that a body of federal substantive law be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Pilot Life*, 481 U.S. at 56.

The Supreme Court expected that a federal common law of rights and obligations under ERISA would develop to regulate plans and remedies. Tomczyk's counsel suggested to the Court of Appeals, Seventh Circuit, that state laws could be utilized in the development of federal common law in ERISA claims. The court condemned that effort as bootstrapping by Tomczyk's counsel of state laws into federal common law. (App. 10; App. 41-43).

The court also condemned Tomczyk's attempts to address the fiduciary responsibility of ERISA as adding a twist and an ostrich like attempt by Tomczyk's counsel to avoid existing authority in an unprofessional and pointless manner. (App. 10).

We point out that the Supreme Court indicates that a beneficiary may bring a cause of action for breach of fiduciary duty. *Pilot Life*, 481 U.S. at 53. We submit that matters of fiduciary duties and state common law rights should be at least discussed and potentially incorporated into federal substantive law dealing with issues involving rights and obligations under private welfare and pension plans in an ERISA context. (App. 39-40). *Cedar Rapids Pediatric Clinic Pension Plan v. Continental Ins. Co.*, 690 F. Supp. 792, 795 (W.D. Ark. 1988).

We particularly ask the Supreme Court to allow Tomczyk counsel to show to the court that they had no intention to mislead or to be unprofessional in appealing Tomczyk. We ask the court to allow us to seek restitution of our reputation. We would like to get a good night sleep. The writer, in 32 years, has never seen a decision that reflects the total antipathy shown in Tomczyk by the Court of Appeals on virtually every issue raised by counsel.

Although the Seventh Circuit has provided that its intention was not intended to chill counsel from bringing actions, this counsel has been thoroughly intimidated and is concerned about the potential repercussions for filing this petition.

We ask the court to allow us to show to the court that Rule 38 sanctions are misplaced in this case.

We are particularly concerned in that *Smith v. Blue Cross & Blue Shield United of Wisconsin*, 724 F. Supp. 618 (E.D. Wis. 1989) is still pending before the Court of Appeals, although oral argument took place on February 14, 1991. Many of the issues in *Smith* are similar to Tomczyk.

We understand the Supreme Court has the authority to summarily decide a case. As an alterative to the court denying the writ, the petitioner would request the court

to exercise its discretion and summarily decide the issues herein. This case, however, raises issues of concern for all attorneys who practice in the Seventh Circuit and for all citizens with an interest in an insured employee benefit plan. If the Supreme Court does not respond to the issues herein, Tomczyk counsel will be at a loss on how to proceed, if at all, in future ERISA cases. It is doubtful that counsel will accept ERISA related cases in the future regardless of their merits. If this was the intended effect of the Seventh Circuit and of Blue Cross, it is likely that they have accomplished their purpose. We do believe that this case raises important issues and that a Writ of Certiorari should issue.

Respectfully submitted,

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Dated: March, 1992

APPENDIX

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 91-1018

JANE TOMCZYK,

Plaintiff-Appellant,

v.

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN,

Defendant-Appellee.

Appeal from the United States District Court
for the Eastern District of Wisconsin.
No. 88 C 690—**Robert W. Warren,** *Judge.*

ARGUED OCTOBER 18, 1991—DECIDED DECEMBER 30, 1991

Before POSNER, FLAUM, and KANNE, *Circuit Judges.*

PER CURIAM. Jane Tomczyk brought this action against Blue Cross and Blue Shield United of Wisconsin (Blue Cross), a Wisconsin non-profit corporation, alleging ERISA, state common-law, and constitutional violations. The District Court granted summary judgment to Blue Cross on the ERISA count, and dismissed the others. Tomczyk appeals the disposition of her ERISA and state common-law claims. We affirm. Moreover, because of the largely frivolous nature of this appeal, as well as the misleading manner in which it was presented to this Court, we impose Rule 38 sanctions on Tomczyk's attorneys, Marjan Kmiec and Christopher McConville of Kmiec Law Offices.

I.

Jane Tomczyk is a member of an ERISA-regulated group health insurance plan issued by Blue Cross and sponsored by her employer. After undergoing oral surgery on October 3, 1987, she filed a claim with Blue Cross for reimbursement of approximately $8,250 in surgical and hospital fees. Blue Cross denied the claim. Tomczyk sued Blue Cross under ERISA for denial of benefits, *see* 29 U.S.C. § 1132(a)(1)(B), (a)(3), brought state common-law claims of bad faith, breach of contract, and tortious interference with her contractual relationship with her doctor, and asserted a constitutional claim under 42 U.S.C. § 1983. She sought reimbursement of her medical costs, as well as extra-contractual compensatory and punitive damages.

The District Court dismissed the state common-law claims as preempted by ERISA, and the § 1983 claim owing to a lack of state action. *See Tomczyk v. Blue Cross & Blue Shield United of Wisconsin*, 715 F. Supp. 914, 918 (E.D. Wis. 1989). In a separate decision granting Blue Cross summary judgment on the ERISA claim, the court determined that no genuine issue of material fact existed and found that Blue Cross had properly denied benefits to Tomczyk under the terms of the contract. *See Tomczyk v. Blue Cross & Blue Shield United of Wisconsin*, No. 88-C-690, slip op. at 13 (E.D. Wis. Dec. 6, 1990). Tomczyk appeals the grant of summary judgment to Blue Cross on the ERISA claim, and the dismissal of her state common law and extra-contractual damage claims. We first examine her ERISA claim.

A.

We review *de novo* the District Court's grant of summary judgment to Blue Cross. *See Doe v. Allied-Signal, Inc.*, 925 F.2d 1007, 1008 (7th Cir. 1991). Summary judgment must be granted if the pleadings and supporting documents "show there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). We must view

the record and all inferences drawn from it in the light most favorable to the nonmoving party. *See Lohorn v. Michal*, 913 F.2d 327, 331 (7th Cir. 1990). The nonmoving party, however, may not rest on its pleadings, and must demonstrate, with specific evidence, that a genuine issue of triable fact remains. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986).

The District Court concluded that the oral surgery performed on Tomczyk was not a covered procedure under her insurance plan. Tomczyk has not appealed the court's *de novo* interpretation of the insurance contract. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (courts must review denial of ERISA plan benefits *de novo* unless the plan gives the administrator discretionary authority to determine benefit eligibility or to construe doubtful or contested terms, in which case the arbitrary and capricious standard applies). Rather, Tomczyk claims that the court should not have granted summary judgment because whether Blue Cross authorized her medical expenses is a disputed factual issue. We disagree.

Tomczyk receives her insurance coverage through the Blue Cross "Advantage Program." Under this program, certain requirements must be met before a plan member may receive full benefits for covered services for nonemergency inpatient hospital care. Blue Cross must determine that the hospitalization is medically necessary and authorize the care. Additionally, the member must notify Blue Cross prior to admission that hospitalization is anticipated, and a length of stay must be authorized. The contract provides that, "[i]f the admission was not preauthorized, benefits will be limited to 80% of the amount otherwise allowed according to the contract provisions for covered benefits." Exhibit A, Section MC, at 74. Moreover, the contract states that even where the hospital stay is preauthorized, "[o]ther limitations, exclusions and conditions of the contract are not affected by this section and still apply." *Id.*

Tomczyk first consulted with John Goeckerman, D.D.S., who subsequently performed the surgery on her jaw, on September 21, 1987. Dr. Goeckerman determined that Tomczyk required corrective treatment consisting of two variations of a surgical procedure known as "osteotomy of the temporo mandibular joint." On September 30, an employee with Dr. Goeckerman's office called Blue Cross's Advantage Program and spoke to Elise McKinch, R.N., a "Managed Care Specialist" who reviews inpatient hospital admissions and authorizes lengths of stay. Tomczyk contends that Blue Cross authorized her October 3 surgery in that telephone conversation.

In her brief, Tomczyk claims that McKinch told Dr. Goeckerman's office that her "insurance was in 'perfect standing' " and that Blue Cross "would cover all medical costs regarding Jane Tomczyk's medically necessary surgery, thereby approving said surgical treatments." Appellant's Br. at 5-6. Nowhere does the record support such an assertion. The sole piece of evidence Tomczyk cites in this regard is Dr. Goeckerman's affidavit. That affidavit, however, states only that McKinch had told his office that Blue Cross "had authorized the hospital stay for the intended surgery," Goeckerman Affidavit at 1, an assertion Blue Cross does not dispute. According to McKinch's affidavit, she informed Dr. Goeckerman's office that she "would authorize a three day inpatient hospital stay." McKinch Affidavit at 2. Significantly, however, her affidavit also states that she informed Dr. Goeckerman's office "that the authorization related to the patient's need to have the procedures done as an inpatient and was not an authorization of coverage," *id.*, and "that it would be advisable to get verification of coverage from Blue Cross' Medical Review department." *Id.* Additionally, because she had determined, and informed Dr. Goeckerman's office, that the procedure might not be covered, she did not send the customary letter confirming admission preauthorization. *Id.* Tomczyk presents no evidence disputing McKinch's statements or showing that Blue Cross authorized the surgery or otherwise agreed to pay for the hospital stay.

Tomczyk's brief argues that since Blue Cross authorized the hospital stay, one can draw a reasonable inference that it also preauthorized the surgery. Appellant's Br. at 9. At oral argument before this Court, Tomczyk's counsel, Christopher McConville, contended that it is also reasonable to conclude that once Dr. Goeckerman obtained the preauthorization for the hospital stay, "he thought he had authority not only for the hospital stay, but for the surgery." McConville's contention is belied by an October 7 letter Dr. Goeckerman sent to Blue Cross. The first sentence reads, "This letter is sent as a request for prior determination of benefits." Plaintiff's Exhibit A. The letter goes on to outline his diagnosis, suggested treatment, and surgical fees. The plain language of the letter shows that, contrary to McConville's assertion, Dr. Goeckerman was indeed aware that Blue Cross had not preauthorized the surgery, which had been performed on October 3.

We are disturbed by the manner in which counsel for Tomczyk manipulated relevant facts. Her brief reads into Dr. Goeckerman's affidavit statements that simply aren't there. The affidavit states only that the hospital stay was preauthorized; it does not state, as Tomczyk's brief claims, that "Blue Cross would cover all medical costs regarding Jane Tomczyk's medically necessary surgery, thereby approving said surgical treatments." Tomczyk's brief also misrepresents the contents of Dr. Goeckerman's letter of October 7, asserting, for example, that Dr. Goeckerman included the cost breakdowns "as a common curtesy" [sic], Appellant's Br. at 6, when the letter clearly is a request for determination of benefits. That Tomczyk's attorney further perpetuated these patently inaccurate characterizations at oral argument only serves to highlight his generally distressing approach in this appeal. We affirm the District Court, and find that no material fact exists regarding whether the surgical treatment was authorized.

Tomczyk's brief asserts further that, at the very least, Tomczyk should be able to recover the costs of her hospital stay. That the hospital stay was preauthorized is not in dispute; Blue Cross has admitted as much. *See* Appellee's

Br. at 4; McKinch Affidavit at 2. Admission preauthorization, however, does not necessarily result in reimbursement. As we have noted, McKinch's affidavit states that she told Dr. Goeckerman's office that this preauthorization related only to the need to have that type of procedure performed as an inpatient, and did not constitute an authorization of coverage. Tomczyk has offered no evidence to counter this statement. While we must review the record in the light most favorable to Tomczyk, she must set forth specific facts showing that there is a genuine issue of material fact which requires a trial. *Celotex*, 477 U.S. at 324. This she has not done. Under the contract, other limitations and conditions of the contract apply to the section pertaining to hospital admission authorization. The District Court held that Tomczyk's surgery was not a covered procedure under the contract. Therefore, Tomczyk is not entitled to recover the costs of the surgery or the hospital stay. The District Court's grant of summary judgment to Blue Cross on the ERISA claim is affirmed.

B.

Tomczyk also appeals the District Court's dismissal of her state common-law claims of bad faith, breach of contract, and tortious interference with contract. As to her bad faith claim, she attempts to circumvent ERISA's broad preemptive provisions by claiming that the Wisconsin law of bad faith is a law which "regulates insurance" and, as such, avoids preemption through ERISA's "saving clause." She attempts to salvage her claims of breach of contract and tortious interference with contract by recharacterizing them as "federal law claims" and urging this Court to therefore consider them as claims for breach of fiduciary duty under ERISA. Appellant's Br. at 19. We reject her arguments.

1.

Tomczyk contends that the Wisconsin law of bad faith escapes ERISA's broad preemptive scope because it is

a law regulating insurance and thus falls within the ambit of ERISA's "saving clause." *See* 29 U.S.C. § 1144(b)(2)(a). ERISA generally preempts any state law which "relates to" employee benefit plans. *Id.* § 1144(a).[1] The saving clause, however, provides that a state law which specifically "regulates insurance" escapes this preemption, *id.* § 1144(b)(2)(A); *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987), unless the plan at issue is self-insured. *Pilot Life*, 481 U.S. at 45; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985).[2] Tomczyk maintains that, because her health plan is insured—a fact the parties do not dispute—and because Wisconsin bad faith law regulates insurance, her bad faith claim falls within the saving clause. In so asserting, Tomczyk ignores the clear mandate of Supreme Court precedent, misstates the holdings of cases she cites in support of her position, and fails to cite

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[1] The "preemption clause" states:

> Except as provided in subsection (b) of this section [the "saving clause"], the provisions of this subchapter and subchapter III of this chapter shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

29 U.S.C. § 1144(a).

[2] The "saving clause" provides:

> Except as provided in subparagraph (B) [the "deemer clause"], nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

29 U.S.C. § 1144(b)(2)(A). The "deemer clause" states:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance . . . for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id. § 1144 (b)(2)(B).

relevant cases from within this Circuit rejecting essentially the same argument—cases, we note, in which Kmiec Law Offices acted as counsel.

In *Pilot Life*—which involved, as here, an insured employee benefit plan—the Supreme Court held that Mississippi bad faith law was not a law regulating insurance within the meaning of § 1144(b). The Court relied primarily on three rationales: the law was not "specifically directed toward the [insurance] industry," 481 U.S. at 50; it did not regulate the transaction of the "business of insurance" under the McCarran-Ferguson Act (*i.e.*, it did not transfer or spread policyholder risk, was not an integral part of the policy relationship between the insurer and insured, and was not limited to entities within the insurance industry), *id.* at 48-49; and allowing the law to escape preemption would violate congressional intent regarding the exclusivity of ERISA's civil enforcement scheme. *Id.* at 57.

Tomczyk attempts to distinguish *Pilot Life* by asserting that, unlike the Mississippi law of bad faith, Wisconsin bad faith law "is directly meant to regulate unfair trade practices within the insurance industry." Appellant's Br. at 15. She cites two cases as authority, *Brockmeyer v. Dun & Bradstreet*, 335 N.W.2d 834 (Wis. 1983), and *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368 (Wis. 1978), neither of which stand for this proposition. *Brockmeyer* did not even address insurance issues; the court merely "refuse[d] to impose a duty to terminate in good faith into employment contracts." 335 N.W.2d at 838. And, although *Anderson* involved insurance, the court did not hold that Wisconsin bad faith law was limited to the insurance industry; indeed, it stated the contrary—that "every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." 271 N.W.2d at 375.

Attempts such as this to mislead this Court were, unfortunately, commonplace in this appeal. Tomczyk continually ignored relevant precedent from this jurisdiction. Her brief failed to cite a case from the Eastern District of

Wisconsin which specifically held that ERISA preempted the Wisconsin tort of bad faith. *See Rust v. Blue Cross & Blue Shield United of Wisconsin*, No. 87-C-0751, 1988 U.S. Dist. *Lexis* 17207 at *11-12 (E.D. Wis. Sept. 21, 1988). Tomczyk's counsel, McConville and Marjan Kmiec, cannot even attempt to claim ignorance as an excuse: they were counsel in *Rust*. We note, too, that the *Rust* opinion cited *Anderson* to support its finding that Wisconsin bad faith law is *not* limited to the insurance context. *Id.* at *11. Tomczyk also failed to cite *Meyer v. Employers Health Ins. Co.*, 722 F. Supp. 547, 552-53 (E.D. Wis. 1989)—yet another case in which McConville was counsel—in which the plaintiff had relied unsuccessfully on the saving clause as a shield against ERISA preemption of common-law claims of breach of contract, tortious interference with a contractual relationship, and intentional infliction of emotional distress.

Finally, Tomczyk's brief gave short shrift to *Maciosek v. Blue Cross & Blue Shield United of Wisconsin*, 930 F.2d 536 (7th Cir. 1991). In *Maciosek*, this Court held that state common-law claims of breach of contract, tortious interference with a contractual relationship, and violation of a Wisconsin common law which prohibits an insurer from recovering payments absent a mistake of fact, were all preempted by ERISA. The *Maciosek* plaintiffs—again represented by McConville and Kmiec—once more relied on the saving clause, this time with regard to the common-law mistake of fact claim. This Court rejected the attempt to circumvent "the clear preemptive mandate of ERISA." *Id.* at 540. We likewise reject Tomczyk's attempt to escape ERISA's "clear preemptive mandate," as well as to avoid dispositive authority. The District Court's dismissal of the bad faith claim is affirmed.

2.

In appealing her claims for breach of contract and tortious interference with her contractual relationship with her doctor, Tomczyk attempts to escape the inescapable

(*i.e.*, preemption) by adding a twist, arguing that this Court should consider these state common-law claims as claims for breach of fiduciary duty under ERISA. Appellant's Br. at 19. This Court in *Maciosek* rejected essentially the same argument, 930 F.2d at 540-41, made by the same counsel, who there even relied on the same case, *Cedar Rapids Pediatric Clinic Pension Plan v. Continental Assurance*, 690 F. Supp. 792 (W.D. Ark. 1988). This "ostrich-like" attempt by Tomczyk's counsel to avoid existing authority "is as unprofessional as it is pointless." *Hill v. Norfolk and W. Ry. Co.*, 814 F.2d 1192, 1198 (7th Cir. 1987). We reject this effort to bootstrap state common-law claims onto the ERISA claim. Moreover, because state law breach of contract and tortious interference with contract claims are preempted by ERISA, *see Pilot Life*, 481 U.S. at 57; *Maciosek*, 930 F.2d at 540; *Meyer*, 722 F. Supp. at 553; *Smith v. Blue Cross & Blue Shield United of Wisconsin*, 724 F. Supp. 618, 621 (E.D. Wis. 1989), we affirm their dismissal.[3]

II.

In bringing this appeal, Tomczyk's counsel, Christopher McConville and Marjan Kmiec (both of Kmiec Law Offices), continue a disturbing pattern of litigating claims that repeatedly advance the same frivolous arguments. This case, the most recent in a litany of nonmeritorious

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[3] Because we affirm the dismissal of both her ERISA and state common-law claims, we need not address Tomczyk's claims for extra-contractual compensatory and punitive damages. Suffice it to note that, although this Circuit had not yet determined the availability of extra-contractual compensatory damages when Tomczyk brought this appeal, we had definitively held that punitive damages are not available under ERISA. *See Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987); *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416, 418 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988). In asserting her punitive damage claim, Tomczyk once again attempted to evade controlling precedent.

ERISA-related cases brought by these attorneys, unfortunately is just one strand in a tangled web of claims manifesting a disregard for the duty of candor that undergirds the judicial system.

In *Smith*, *supra*, the plaintiff, through Kmiec, alleged breach of contract, bad faith breach of contract, breach of fiduciary duty, and intentional infliction of emotional distress, and sought punitive damages. As here, the plaintiff in *Smith* argued that the state law claims should not be preempted by ERISA because of the saving clause. Citing *Pilot Life and Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1986), as well as the District Court decision in *Tomczyk*, *Smith* held that the state law claims and the claim for punitives were preempted by ERISA. Stating that the lawsuit was "patently frivolous," the court imposed Rule 11 sanctions, noting that "the arguments plaintiffs' counsel advances are not good faith reasoning for modification or reversal of the controlling law, but fly in the face of even having read these decisions." 724 F. Supp. at 622-23.

Despite the strong language and clear holding of *Smith*, McConville and Kmiec briefed the *Tomczyk* appeal with only a single reference to it—a comment that "some of these issues herein are currently pending before the Seventh Circuit" and a reservation of the right to amend the brief should *Smith* be decided during the pendency of the *Tomczyk* appeal. Appellant's Br. at 4-5. The brief failed to substantively address the District Court opinion in *Smith*, state its holding, dispute its reasoning, or attempt in any way to distinguish it from the case at hand.

Similarly, Tomczyk's brief failed to adequately address this Court's decision in *Maciosek*. As with *Smith*, the sole reference to *Maciosek* was the comment reserving the right to amend if *Maciosek* were decided during the pendency of Tomczyk's appeal. Unlike *Smith*, *Maciosek* was issued during the pendency. *Maciosek* specifically held that the plaintiffs' claims for breach of contract, tortious interference with a contractual relationship, and inten-

tional infliction of emotional distress were preempted by ERISA, 930 F.2d at 540, and could not be saved by construing them as ERISA claims. *Id.* Rather than acknowledge the unfavorable holding, counsel for Tomczyk chose to misinform this Court. In their reply brief—in which, we note, they were effectively forced to address *Maciosek* following its prominent mention in Blue Cross's brief—Tomczyk's attorneys make the specious argument that "[t]he use of *Maciosek* herein is inapplicable" because

> [t]he *Maciosek* case was not a bad faith case, but instead was treated by the court and parties as a violation of Wisconsin Common Law which prohibited an insurer from recovering mistaken payments unless the payment was caused by a mistake of fact.

Appellant's Reply Br. at 2. This assertion is patently incorrect. The *Maciosek* opinion specifically states that "[t]he state law causes of action . . . obviously are preempted under the Supreme Court's construction of ERISA." 930 F.2d at 540. *Maciosek* is directly applicable to the present case, and its holding obviously precludes Tomczyk's state law claims.

In sanctioning the plaintiff's attorneys in *Smith*, the court admonished that "[c]ounsel cannot ignore settled precedent and bring repeated suits that have no basis in the law." 724 F. Supp. at 624. Similarly, this Court in *Maciosek* affirmed the District Court's imposition of Rule 11 sanctions, chastising counsel for failing to "discuss or distinguish existing law." 930 F.2d at 542. In particular, we criticized Maciosek's counsel for omitting a case from the Eastern District of Wisconsin—namely, *Tomczyk*. *See* 930 F.2d at 541 ("not only did he file this claim after *Tomczyk*, he failed to distinguish it, argue it was wrongly decided, or even acknowledge its existence."). This Court admonished:

> Kmiec argues that the ERISA claims in *Tomczyk* were still pending at the time the Macioseks' claims were filed, so the decision was not a final judgment and no appeal was possible. While that is true, it does

> not explain why Kmiec failed to distinguish a case from the Eastern District of Wisconsin that directly resolved two of the Macioseks' claims. Ignoring precedent from the same jurisdiction is not making a "good faith argument for the extension, modification, or reversal of existing law . . . ." Fed. R. Civ. P. 11. And like it or not, *Tomczyk* was the "existing law" of the district court when these claims were filed, and when Kmiec filed his brief in opposition to the motion to dismiss.

Maciosek, 930 F.2d at 542.

The lessons of *Maciosek* and *Smith* apparently did not take. Tomczyk's brief to this Court failed to adequately discuss or distinguish *Smith* or *Maciosek*, the very cases in which Kmiec and McConville were cited for ignoring existing precedent. Even more egregious, at oral argument, Tomczyk's counsel attempted to explain away the brief's failure to adequately address this Court's decision in *Maciosek* by asserting that it was rendered during the pendency of the *Tomczyk* appeal—the very same argument used (and rejected) before this Court in *Maciosek* as a rationale for failing to address *Tomczyk*!

Moreover, just as the *Maciosek* brief failed to cite the District Court's decision in *Tomczyk*, Tomczyk's brief failed to cite yet another Eastern District of Wisconsin decision, *Meyer v. Employers Health Ins. Co.*, *supra*, despite *Meyer*'s holding that ERISA preempts state-law breach of contract and tortious interference with contract claims and, therefore, its obvious relevance to the present case. When confronted at oral argument with this omission, McConville again mislead this Court, asserting that *Meyer* was inapplicable because it involved a self-insured plan (itself a specious distinction) when in truth, *Meyer*, as here, involved an insured plan.

This tactic of ignoring existing, and potentially dispositive, precedent, as well as the numerous attempts to mislead this Court through bold misrepresentations of fact and law, disserve the parties, opposing counsel, and this

Court. *See Hill*, 814 F.2d at 1198. Under Rule 38, Fed. R. App. P., this Court may award just damages and single or double costs to the appellee if we determine that an appeal is frivolous. We use a two-step process to determine whether sanctions should be issued under this rule: "we must first determine that the appeal is frivolous, and then determine that this is an appropriate case for the imposition of sanctions." *Williams v. United States Postal Serv.*, 873 F.2d 1069, 1075 (7th Cir. 1989); *see Mays v. Chicago Sun-Times*, 865 F.2d 134, 183 (7th Cir. 1989). The rule authorizes sanctions even if the presence of a colorable ground prevented the entire appeal from being adjudged frivolous. *Hill*, 814 F.2d at 1200. We find that this appeal is an appropriate one for sanctions.

Before turning to the specifics of this case, we wish to make clear that it is not our intent to "chill" discussion or to dissuade counsel from bringing credible appeals. Rather, it is our objective to protect the integrity of this system by enforcing attorneys' ethical responsibilities, and to preserve the availability of the federal courts for worthy claims by deterring groundless appeals. *See Hill*, 814 F.2d at 1203; *Mays*, 865 F.2d at 139. We do not seek to make this Court a veritable "minefield" for litigants as they determine whether to pursue appeals. An honest presentation of the case, adherence to the basic technical rules, and a colorable basis in law and fact—as well as a certain amount of common sense—will shield litigants and their attorneys from sanctions. Unfortunately, the attorneys for the appellant in this case transgressed these wide boundaries.

"An appeal is frivolous when the result is obvious or when the appellant's argument is wholly without merit." *Mays*, 865 F.2d at 138 (quoting *Indianapolis Colts v. Mayor of Baltimore*, 775 F.2d 177, 184 (7th Cir. 1985)). Tomczyk's state common-law claims, mimicking others which have consistently been dismissed as preempted by ERISA by this Court and others in this Circuit, obviously fit this description. Likewise, the claim for punitive damages had no colorable basis in the law, was "patently groundless,"

Hill, 814 F.2d at 1200, and therefore frivolous. The appeal of the state common-law and punitive damages claims constituted an "insistence on litigating a question in the face of controlling precedents which removed every colorable basis in law for the litigant's position." *Reid v. United States*, 715 F.2d 1148, 1154 (7th Cir. 1983). Moreover, seeking more than $10 million in punitive damages in this case was "clearly excessive." *Mestayer v. Wisconsin Physicians Serv. Ins. Corp.*, 905 F.2d 1077, 1080-81 (7th Cir. 1990). Counsel for Tomczyk previously have been sanctioned by this Court for seeking such unreasonable damage awards in a case of this nature. *Id.*

We previously have held that misrepresentations of controlling law and disingenuous arguments, "because they postpone resolution of the real issues and cause delay, can be evidence of bad faith under the second part of the Rule 38 analysis." *Williams*, 873 F.2d at 1075 (quoting *Beam v. IPCO Corp.*, 838 F.2d 242, 249 n.5 (7th Cir. 1988)). Such offenses were mainstays of Tomczyk's brief. Many of the cases cited to support Tomczyk's claims were "neither controlling nor relevant." *Morris v. Jenkins*, 819 F.2d 678, 681 (7th Cir. 1987). When the law disfavored Tomczyk's case, it was ignored, glossed over, or misstated. Puffery was proffered as fact. Her attorneys presented the record "in a thoroughly misleading and unprofessional fashion," further demonstrating frivolousness. *Borowski v. DePuy, Inc.*, 850 F.2d 297, 306 (7th Cir. 1988) (citation omitted). The "entire manner in which [this] appeal has been pursued justifies sanctions." *Id.* at 305-06.

Because of the aforementioned conduct before this Court, we have determined that a significant penalty is warranted. Accordingly, we impose sanctions in the amount of $2,000 against Tomczyk's attorneys.[4] Further, Tomczyk's attor-

[4] This Circuit has on several occasions imposed a flat sum award as "damages" under Rule 38 without having evidence of attorneys' fees and other expenses before it. *See, e.g., Cheek v. Doe*, 828 F.2d

(Footnote continued on following page)

neys shall be assessed the costs of this appeal. Blue Cross shall submit to the clerk of this Court within fifteen days of the date of this opinion proper documentation of its expenses in defending this appeal. Counsel for Tomczyk will have an opportunity to contest the amount requested by Blue Cross.

AFFIRMED WITH SANCTIONS.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

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[4] *continued*

395, 398 (7th Cir. 1987) ($1500 award); *Hilgeford v. Peoples Bank*, 776 F.2d 176, 179 (7th Cir. 1985) ($500 award), *cert. denied*, 475 U.S. 1123 (1986).

Additionally, as this Court noted in *Hill*, 814 F.2d at 1202, a hearing is not necessarily required by Rule 38. A hearing is required only if there is a contested factual issue. Because no such issue exists in our finding that counsel made objectively groundless legal arguments and factual misstatements, no hearing is warranted in this case.

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

JUDGMENT—WITH ORAL ARGUMENT

Date: December 30, 1991

BEFORE: Honorable Richard A. Posner, Circuit Judge
Honorable Joel M. Flaum, Circuit Judge
Honorable Michael S. Kanne, Circuit Judge

No. 91-1018

JANE TOMCZYK,

Plaintiff-Appellant

v.

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN,

Defendant-Appellee

Appeal from the United States District Court for the Eastern District of Wisconsin
No. 88 C 690, Judge Robert W. Warren

This cause was heard on the record from the above mentioned district court, and was argued by counsel.

On consideration whereof, IT IS ORDERED AND ADJUDGED by this Court that the judgment of the District Court in this cause appealed from be, and the same is hereby, AFFIRMED, with sanctions Tomczyk's attorneys shall be assessed the costs of this appeal, in accordance with the opinion of this Court filed this date.

[FILED DECEMBER 6, 1990]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

JANE TOMCZYK,

Plaintiff,

v. Case No. 88-C-690

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant.

DECISION AND ORDER

I. BACKGROUND

The plaintiff, Jane Tomczyk, brought suit against Blue Cross and Blue Shield United of Wisconsin and First Financial Savings Association for arbitrary and capricious denial of benefits under ERISA, bad faith, breach of contract, tortious interference with contract, and violations of constitutional rights under § 1983.

After the plaintiff stipulated to the dimissal of defendant First Financial Savings Association, defendant Blue Cross and Blue Shield moved for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. This Court dismissed the plaintiff's state law claims for bad faith, breach of contract and tortious interference with contract and the plaintiff's § 1983 claim. *See Tomczyk v. Blue Cross and Blue Shield United of Wisconsin*, 715 F. Supp. 914 (E.D. Wis. 1989). However, the Court held in abeyance defendant's motion for summary judgment on

the mertits of the lawsuit—*i.e.*, whether plaintiff was entitled to reimbursement of charges incurred for oral surgeries. The Court requested the parties to file supplementary briefs discussing the United States Supreme Court's decision in *Firestone Tire and Rubber v. Burch*, 109 S.Ct. 948 (1989). In *Firestone*, the court held that a denial of benefits challenged under § 1132(a)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine the eligibility for benefits or to construe the terms of the plan. *See id.* at 987.

This Court also held in abeyance defendant's motion to strike plaintiff's demand for a jury trial. In addition, plaintiff has submitted a motion for reconsideration of this Court's dismissal of her state law claims.

II. DEFENDANT'S MOTION FOR SUMMARY JUDGMENT ON PLAINTIFF'S ERISA CLAIM

A. *Summary Judgement Standard*

A motion for summary judgment shall be granted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. Fed.R.Civ.P. 56(c). Further, "[i]n reviewing a summary judgment, we must view the record and inferences drawn from it in the light most favorable to the nonmoving party." *Schlifke v. Seafirst Corp.*, 866 F.2d 935, 937 (7th Cir. 1989). However, a scintilla of evidence is not enough to defeat a motion for summary judgment; the nonmovant must go beyond the pleadings by affirmatively demonstrating the existence of a genuine issue of material fact. *Id.* at 938.

B. *Factual Background*

Before this Court addresses the question of whether the defendant properly interpreted the contract, it must address what plaintiff considers to be a dispute of material fact among the parties which prevents summary judgment. Plaintiff and defendant agree on several preliminary facts. However, plaintiff asserts that the parties dispute whether preauthorization review of plaintiff's surgery occurred prior to her surgery.

1. *Undisputed Facts*

First Financial Savings Association, plaintiff's employer, issued a hospital and medical policy of insurance to plaintiff. This policy was in effect at all times relevant to this case.

On September 21, 1987, plaintiff first saw Dr. John A Goeckerman, D.D.S., regarding corrective surgery. After this first consultation, Dr. Goeckerman opined that plaintiff had experienced a developmental skeletal deformity of her maxilla and mandible. Dr. Goeckerman found that plaintiff's deformity would require corrective surgical treatment. Dr. Goeckerman's chosen treatment for plaintiff consisted of two variations of a surgical procedure known as "osteotomy of the temporo mandibular joint."

2. *Disputed Facts*

Defendant asserts that on September 30, 1987, a "Kathy" from Dr. Goeckerman's office telephoned defendant's Advantage Program to get preauthorization of plaintiff's in patient hospital stay for surgery. Defendant states that its employee, Elise McKinch, who took the call, authorized a three-day hospital stay for plaintiff, subject to the terms

and conditions of the contract. Defendant states that Ms. McKinch informed Kathy that defendant's Medical Review Department's preauthorization would be needed for the surgical procedure. Affidavit of Elise McKinch, R.N. Defendant states that the usual follow-up letter from the Advantage Program, confirming the stay was not sent because of the question about coverage. *See Id.*

In her brief in opposition to defendant's motion for summary judgment, plaintiff, through her attorney, asserts that on September 30, 1987, Dr. Goeckerman's office contacted defendant to obtain a preauthorization of plaintiff's surgery. *See* Affidavit of John A. Goeckerman, DDS. Plaintiff further states in her brief that a representative of defendant stated that "plaintiff's insurance was in 'perfect standing' and that her insurance would cover all medical costs regarding the plaintiff's medically necessary surgery, thereby approving said surgical treatments." *See* plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment, p. 2. Plaintiff, through her attorney, asserts that the Affidavit of Dr. Goeckerman supports the propositin that defendant preauthorized her surgical treatments. Dr. Goeckerman's affidavit states in part:

> That on September 30, 1987, your affiant's office contacted the defendant, Blue Cross, for the purpose of obtaining a preauthorization of the plaintiff's surgery. *That a representative of the defendant, Blue Cross, stated that the plaintiff's insurance had authorized the hospital stay for the intended surgery.*

The affidavit of Dr. Goeckerman clearly states that his office sought preauthorization of the plaintiff's surgery. However, it does not state that defendant authorized such surgery. Rather, it merely states that plaintiff's insurance authorized the hospital stay for plaintiff's surgery.

Because plaintiff presents no evidence in support of her proposition that defendant preauthorized plaintiff's surgery, there is no dispute as to material facts between the parties.

C. *Application of the Firestone Decision to Our Case*

In *Firestone*, the Supreme Court established the standards of review to be used in civil actions to recover benefits under 19 U.S.C. § 1132(a)(1)(B). The *Firestone* court stated:

> Consistent with the established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or a fiduciary discretionary authority to determine the eligibility for benefits or to construe the terms of the plan.

109 S.Ct. at 956.

1. *Whether the De Novo or Arbitrary and Capricious Standard Applies in Our Case*

Defendant asserts that the benefit plan gives it the discretionary authority to construe the terms of the plan and that, therefore, the arbitrary and capricious standard of review is the correct standard. In support of its assertion, defendant notes that under the plan, defendant makes the determination whether an inpatient hospital admission is "medically necessary". The defendant admits that the plan is silent on defendant's authority to construe the terms of the surgery section of the contract. However, defendant asserts that, since the plan has delegated to defendant the authority to determine the con-

troversial and difficult health care concept of medical necessity, the plan must also intend to give discretionary authority to defendant to construe all plan terms.

The Court is not persuaded by defendant's argument. In *Firestone*, the Supreme Court established a gap-filling rule concerning the standard of review to be applied to benefit denials. The Supreme Court held that the parties to a plan could, if they so desired, contract around the gap-filling standard by "agreeing upon a narrower standard of review." *See id.* at 956. Defendant presents no direct evidence that the parties intended to contract around the *de novo* standard for denials of surgery. Instead, defendant merely points to a grant of discretion in another context. However a grant of discretion in one context does not mean that discretionary authority was granted in all contexts. Rather, the fact that the parties chose to explicitly grant discretionary authority in one context and did not do so in another indicates, if anything, that they intended to have discretionary authority in one area and not in the other.

2. *Application of the De Novo Standaard of Review to Defendant's Denial of Benefits*

Section SM-Surgical/Medical Benefits of the insurance contract governs whether plaintiff has coverage. The section provides in part:

> SECTION SM—SURGICAL/MEDICAL BENEFITS
>
> Subject to the limitations, exclusions and conditions of this CONTRACT, a MEMBER is entitled to COVERED SERVICES described in this Section when rendered by PHYSICIANS or PROFESSIONAL OTHER PROVIDERS acting within the scope of

their respective licenses, in the amounts specified in the Schedule of Benefit.

A. *Surgical Services*

1. Surgery

SURGERY, wherever performed, by a PHYSICIAN or PROFESSIONAL OTHER PROVIDER, COVERED SERVICES FOR SURGERY include pre- and post-operative services. Diagnostic x-ray services necessary for the diagnosis of and related to covered surgical procedures are a benefit.

Subsequent surgical procedures (i.e. suture, cast removal), which are normally considered to be an integral part of the prevailing FEE FOR THE INITIAL SURGICAL PROCEDURE, will be considered for payment as a separate service only when performed by a PHYSICIAN other than the operating surgeon.

Surgical services include OUTPATIENT Electroshock Therapy.

2. Special Surgery

a. *Reconstructive Surgery*

SURGERY to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes; but does not include transsexual SURGERY.

. . .

c. *Oral Surgery*

Oral Surgery limited to the following:

1. Surgical exposure or removal of impacted teeth.

2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

3. Surgical procedures required to correct accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such injuries are incurred while a MEMBER is covered under this CONTRACT.

4. Apiccectomy—excision of Apex or tooth root.

5. Excision of exostoses of the jaws and hard palate.

6. Treatment of fractures of facial bones.

7. External incision and drainage of cellulitis.

8. Incision of accessory sinuses, salivary glands or ducts.

9. Reduction of dislocations of, and excision of, the temporomandibular joints.

10. Gingivectomy—Excision of loose gum tissue to eliminate infection.

11. Alveolectomy—The leveling of structures supporting teeth for the purpose of fitting dentures.

12. Frenectomy—Incision of any mid-line fold of tissue between the jaws and lips and between the lower jaw and tongue.

13. Removal of retained (residual) root.

14. Gingival curettage under general anesthesia.

15. Apical curettage.

Section A.1., Surgery, outlines what is included as covered services for surgery. Subsection A.2., Special Surgery, states which types of surgery are covered. The subsection on reconstructive surgery, A.2.a., provides coverage for all corrective surgery except transsexual surgery. The subsection on oral surgery, A.2.c., excludes from oral surgery the surgeries not listed.

Plaintiff asserts that Section SM of the insurance contract is ambiguous because subsections A.2.a. and A.2.c.

are in conflict. Plaintiff states that while she clearly falls within the coverage of the reconstructive surgery subsection, she does not fall within the oral surgery subsection. Plaintiff further asserts that this ambiguity should be construed against the defendant in order to provide coverage for the plaintiff.

It is well settled that ambiguities in an insurance contract are to be construed in favor of the insured. *See Kennedy v. Washington National Insurance Co.*, 136 Wis. 2d 425, 428-29, 401 N.W.2d 842 (1986). In *Caporali v. Washington National Insurance Co.*, 102 Wis. 2d 669, 765-76, 307 N.W.2d 218, 221 (1981) (quoting *Gary Garriguenc v. Love*, 67 Wis. 2d 130, 134-35, 226 N.W.2d 414, 417 (1975)), the Wisconsin Supreme Court restated the standards for construction of terms in insurance policies:

> In the case of an insurance contract, the words are to be construed in accordance with the principle that the test is not what the insurer intended the words to mean but what a reasonable person in the position of an insured would have understood the words to mean. Whatever ambiguity exists in a contract of insurance is resolved in favor of the insured. This is a restatement of the general rule that ambiguous contracts are to be construed most strongly against the maker or drafter. Words or phrases in a contract are ambiguous when they are reasonably or fairly susceptible to more than one construction.

Defendant asserts that Section SM is not ambiguous because it is not reasonably or fairly susceptible to more than one construction. Defendant cites several well-settled rules of contract interpretation which it asserts eliminate any possibility of ambiguity in the contract. Defendant first cites the well-settled principle that a construction of a contract rendering some language useless or surpluage is to be avoided. *See, e.g., Baker v. MeDell Corp.*, 13 Wis.

2d 71, 76-77, 191 N.W.2d 846 (1971). Corpus Juris Secundum outlines this principle of contract construction.

> A construction neutralizing, nullifying, or annulling one provision should not be adopted if the contract can be construed so as to give effect to all of its provisions, and a construction rendering a provision, term, or pare meaningless, superfluous, useless, inexplicable, or nugatory should be avoided.

17A C.J.S. Contracts § 297, p. 125. Because the subsection on reconstructive surgery covers all corrective surgery and since the subsection on oral surgery covers a particular type of corrective surgery, the subsection on oral surgery must be read as a limitation of the reconstructive surgery subsection or be rendered meaningless. If an insured undergoing oral surgery is allowed coverage if he or she falls within either subsection A.2.a. or subsection A.2.c., the insured will always be granted coverage and subsection A.2.c. will become meaningless.

Defendant also cited the well-settled principle that general provisions in contracts yield to specified ones, but where both may be given reasonable effect both are retained. *See, e.g., Johnson v. Green Bay Packers*, 272 Wis. 149, 162, 74 N.W.2d 784, 790-91 (1956) (citing 17 C.J.S., Contracts, § 313, p. 731). In our case, reasonable effect can be given to both subsections only by allowing the oral surgery subsection to be a limitation upon the reconstructive surgery subsection. Otherwise, as stated above, the reconstructive surgery subsection will subsume the oral surgery subsection and make it meaningless.

Finally, defendant cited the principle that a court should choose a contract construction which gives harmonious effect to all the contract's covenants rather than a construction which provides a conflict among some of its covenants. *See, e.g., Bitker & Gerner Co. v. Green Inv. Co.*,

273 Wis. 116, 120, 76 N.W.2d 594, 552 (1956). In our case, only the construction which holds that the oral surgery subsection is a limitation of the reconstructive surgery subsection gives harmonious effect to both subsections. A construction which holds that an insured may have coverage if he or she falls within either subsection creates a conflict between the subsections and makes the oral surgery subsection meaningless.

Read in accordance with settled principles of contract construdtion, Section SM unambiguously limits oral surgery to those listed in the oral surgery subsection. Consequently, this Court finds, under a *de novo* standard of review, that defendant properly denied benefits to plaintiff.

III. PLAINTIFF'S MOTION TO RECONSIDER THE COURT'S DISMISSAL OF HER STATE CAUSES OF ACTION

Plaintiff asks that this Court reconsider its dismissal of her claims of bad faith, breach of contract and tortious interference with contract. Plaintiff states that the Court failed to consider her argument that the Seventh Circuit distinguished between insured and self-insured plans. *See Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416 (1988). Plaintiff argues that because the *Reilly* court held that insured plans, such as the one in our case, are affected by state laws which regulate the insurance industry, claims against such plans are saved from ERISA preemption.

Plaintiff is correct that the *Reilly* court distinguishes insured from self-insured plans. *See id.* at 425. The *Reilly* court held that with self-insured plans, ERISA's "deemer clause" applies and therefore the benefit plan cannot avoid preemption *See id.* Because the benefit plan cannot avoid

preemption, the *Reilly* court stated that it "need not decide whether Wisconsin law concerning punitive damages and bad faith 'regulates insurance.' " *See id.* (citing 29 U.S.C. § 1144(a) (ERISA's "Savings Clause")).

In our case, because the benefit plan in question is not self-insured, this Court was required to determine whether the state law concerning bad faith, breach of contract and tortious interference with contract regulates insurance. This Court applied the test set out by the Supreme Court in *Pilot Life Insurance Co. v. Dedreaux* to determine whether the state law regulates insurance, 481 U.S. 41, 48-49 (1986), and found that it did not.

IV. DEFENDANT'S MOTION TO STRIKE PLAINTIFF'S DEMAND FOR A JURY TRIAL

Because this Court has granted defendant's motions for summary judgment, it is not necessary to address defendant's motion to strike plaintiff's demand for a jury trial.

V. SUMMARY

Under the foregoing reasoning, the Court: (1) GRANTS defendant's motion for summary judgment on plaintiff's ERISA claim; (2) DENIES plaintiff's motion to reconsider the Court's dismissal of her state law claims and (3) DOES NOT CONSIDER defendant's motion to strike plaintiff's demand for a jury trial.

SO ORDERED this 6th day of December, 1990, at Milwaukee, Wisconsin.

/s/ Robert W. Warren
ROBERT W. WARREN
UNITED STATES DISTRICT JUDGE

[FILED MAY 8, 1989]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

JANE TOMCZYK,

Plaintiff,

vs. Case No. 88-C-690

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant.

DECISION AND ORDER

The plaintiff, Jane Tomczyk, brought suit against Blue Cross & Blue Shield United of Wisconsin and First Financial Savings Association for (1) arbitrary and capricious denial of benefits presumably under the Employee Retirement Security Act of 1974 (ERISA), as amended, 29 U.S.C. § 1000 *et seq.*; (2) bad faith; (3) breach of contract; (4) tortious interference with contract; and (5) violation of constitutional rights under section 1983. The plaintiff seeks punitive damages and other extra-contractual damages.

The plaintiff stipulated to the dismissal of defendant First Financial Savings Association. Defendant Blue Cross & Blue Shield United of Wisconsin now moves for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure, on the grounds that there is no controversy with respect to any fact necessary to determine the correctness of defendant's decision denying plaintiff's claim for benefits.

Alternatively, defendant moves the Court for an order, pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure, dismissing plaintiff's claims for bad faith, breach of contract, tortious interference with contract, punitive and other extra-contractual damages on the grounds that these state law causes of action are pre-empted by the provisions of ERISA; for an order dismissing plaintiff's section 1983 claim on the ground that no state action is alleged; and for an order dismissing plaintiff's demand for trial by jury.

The Court dismisses the plaintiff's state law claims for bad faith, breach of contract, tortious interference with contract, and punitive and other extra-contractual damages. The Court also dismisses the plaintiff's section 1983 claim. The Court holds in abeyance the motion for summary judgment. In light of *Firestone Tire & Rubber Co. v. Bruch*, Case No. 87-1054 (U.S. Feb. 21, 1989) (a denial of benefits challenged under section 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan), the Court requests the parties to supplement their briefs with a discussion of this recent Supreme Court case. The Court further holds in abeyance the defendant's motion for a jury trial.

I.

Blue Cross issued a policy of group health insurance to the Wisconsin League of Financial Institutions, Ltd. (Savings League). At all times relevant to this action, Jane Tomczyk was employed by First Financial Savings Association. Through its membership in the Savings League, First Financial Savings Association was able to procure

insurance for its employees under the Savings League's program with Blue Cross. Jane Tomczyk was a subscriber under this program of insurance.

II.

In ERISA, Congress set out to:

> "protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." § 2, as set forth in 29 U.S.C. § 1001(b).

ERISA comprehensively regulates, among other things, employee welfare benefit plans that, "through the purchase of insurance or otherwise" provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. § 3(1), 29 U.S.C. § 1002(1).

Congress capped off the massive undertaking of ERISA with three provisions relating to the preemptive effect of federal legislation:

> "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." § 514(a), as set forth in 29 U.S.C. § 1144(b)(2)(A) (saving clause).
>
> "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment com-

> pany or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." § 54(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (deemer clause).

To summarize the pure mechanics of the provisions quoted above: If a state law 'relate[s] to . . . employee benefit plan[s]," it is pre-empted. § 514a. The saving clause excepts from the pre-emption clause laws that "regulat[e] insurance." § 514(b)(2)(A). The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).

"[T]he question whether a certain state action is preempted by federal law is one of congressional intent. ' "The purpose of Congress is the ultimate touchstone." ' " *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208 (1985), *quoting Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978), *quoting Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963). We have observed in the past that the express pre-emption provisions of ERISA are deliberately expansive, and designed to "establish pension plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). As we explained in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983):

> "The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R. Conf. Rep. No. 93-1280, p. 383 (1974); S.Conf. Rep. No. 93-1090, p. 383 (1974)."

> The House and Senate sponsors emphasized both the breadth and importance of the pre-emption provisions. Representative Dent described the "reservation to Federal authority the sole power to regulate the field of employee benefit plans" as ERISA's "crowning achievement." 120 Cong. Rec. 29197 (1974). Senator Williams said:
>
> > "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of the employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force and effect of law." *Id.*, at 29933.
>
> See also *Shaw v. Delta Air Lines, Inc.*, *supra*, at 99-100, n.20 (describing remarks of Sen. Javits).

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44-46 (1986).

The state law causes of action in the plaintiff's complaint relate to an employee benefit plan and therefore fall under ERISA's express preemption clause, section 514(a). A law relates to a benefit plan if it has a connection with or reference to such a plan. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 47. The pre-emption clause is not limited to "state laws specifically designed to affect employee benefit plans." *Pilot Life*, 481 U.S. at 48, *citing Shaw v. Delta Air Lines*, 463 U.S. 85, 98 (1983).

Unless these causes of action fall under an exception to section 514(a), therefore, they are expressly pre-empted.

> In *Metropolitan Life*, we were guided by several considerations in determining whether a state law falls under the saving clause. First, we took what

> guidance was available from a "common sense view" of the language of the saving clause itself. 471 U.S., at 740. Second, we made use of the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, in interpreting the saving clause. Three criteria have been used to determine whether a practice falls under the "business of insurance" for purposes of the McCarran-Ferguson Act:
>
> "*[F]irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, *cert. denied*, the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (emphasis in original).

Pilot Life Insurance Co. v. Dedreaux, 481 U.S. at 48-49.

The Supreme Court determined that the Mississippi law of bad faith does not "regulate insurance" under a common sense view. *Pilot Life*, 481 U.S. at 50. "Mississippi's law of bad faith, even if associated with the insurance industry, has developed from general principles of tort and contract law available in any Mississippi breach of contract case." *Pilot Life*, 481 U.S. at 51. The Wisconsin law of bad faith is also firmly rooted in general principles of tort and contract law. As the Wisconsin Supreme Court has noted in discussing bad faith, "Every contract imposes upon each party a duty of good faith and fair dealing in its performance and enforcement." *Anderson v. Continental Insurance*, 85 Wis.2d 675, 689, 271 N.W.2d 368, 375 (1978). *See also Rust v. Blue Cross & Blue Shield*, No. 87-C-0751 (E.D. Wis. Sept. 21, 1988) (J. Warren, presiding).

The Supreme Court also held that the Mississippi law of bad faith does not regulate insurance within the mean-

ing of the McCarran-Ferguson Act. *Pilot Life*, 481 U.S. at 50. Likewise, the Wisconsin law of bad faith does not regulate insurance within the meaning of the Act. It does not effect a spreading of policyholder risk; it does not define the terms of the relationship between the insurer and the insured, it only declares that a breach of contract may in certain circumstances allow the policyholder to obtain punitive damages; and, finally, it is not limited to entities in the insurance industry.

The Supreme Court finally held that it was the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive. *Pilot Life*, 481 U.S. at 57.

Based on the *Pilot Life* analysis, the Court concludes that the tort of bad faith in Wisconsin is pre-empted and not saved by ERISA. The plaintiff's other state law causes of action, breach of contract and tortious interference with contract also are pre-empted by ERISA. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1986) (common law contract and tort claims are pre-empted by ERISA under *Pilot Life* and are not saved). The Court therefore DISMISSES the plaintiff's bad faith, breach of contract, and tortious interference with contract claims.

III.

Because ERISA pre-empts state law causes of action, the plaintiff's only viable cause of action is under ERISA, which provides for the following recovery:

> A civil action may be brought:
>
> (1) by a participant or beneficiary—
>
> (A) for the relief provided for in subsection (c) of this section or

> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [§29 U.S.C. § 1109];
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

29 U.S.C. § 1132.

The Supreme Court has stated that "there is a stark absence—in the statute itself and in its legislative history—of any reference to an intention to authorize the recovery of extracontractual damages." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1984). The Court therefore held that plaintiff did not have a cause of action for extracontractual damages caused by improper or untimely processing of benefit claims under 29 U.S.C. § 1132(a)(2). In addition, the Court of Appeals for the Seventh Circuit has held that plaintiff did not have a cause of action for punitive damages under 29 U.S.C. § 1132(a)(3). *Klinhans v. Lisle Sav. Profit Sharing Trust*, 810 F.2d 618, 636-627 (7th Cir. 1987). Based on these cases, the Court DISMISSES the plaintiff's claims for extracontractual damages.

IV.

An action under section 1983 is available only if "state action" is present. *Ezpeleta v. Sisters of Merch Health Corp.*, 800 F.2d 119, 133 (7th Cir. 1986). The plaintiff purports to satisf the state action requirement by asserting

that "Blue Cross is licensed and extensively regulatd by the Insurance Commissioner pursuant to state law, under the Wisconsin Administrative Code, Ins. 1.01-20.01, Wis. Adm. Code." "It is settled, however, that the mere existence of detailed regulation of a private entity does not make every act, or even every regulated act, of the private firm, the action of the State." *Cohen v. Illinois Institute of Technology*, 524 F.2d 818, 826 (7th Cir. 1975). "Unless it is alleged that the regulatory agency has encouraged the practice in question, or at least given its affirmative approval to the practice, the fact that a business or institution is subject to regulation is not of decisive importance." *Id.* The defendant's decision to deny benefits is "a purely private one", notwithstanding that it is licensed and regulated by the state. *Koller v. Aetna Life Insurance Co.*, Case No. 87-C-903, slip op. at 2 (E.D. Wis., Mar. 1, 1988) (J. Stadtmueller, presiding). Because the plaintiff has failed to allege facts which would support her allegation that Blue Cross acted under color of state law in denying her claims, the Court DISMISSES the plaintiff's section 1983 claim.

V.

The Court has approved the parties' stipulation for an extension of discovery to a date following the Court's resolution of the pending summary judgment motion. The Court therefore has taken the pretrial conference scheduled for May 9, 1989 off the Court's calendar. The conference will be rescheduled, if appropriate, in the order resolving the motion for summary judgment.

SO ORDERED this 8th day of May, 1989, at Milwaukee, Wisconsin.

/s/ Robert W. Warren
ROBERT W. WARREN
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
Case No.: 91-1018

JANE TOMCZYK,

Plaintiff-Appellant,

v.

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant-Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN,
THE HONORALE ROBERT W. WARREN, PRESIDING, OF
DECISIONS AND ORDERS GRANTING SUMMARY
JUDGMENT IN FAVOR OF THE DEFENDANT-APPELLEE.

APPELLANT'S BRIEF AND APPENDIX

KMIEC LAW OFFICES
3741 West National Avenue
Milwaukee, WI 53215
(414) 649-9790

* * * * *

[p. 19] considered state law claims, are in fact, now federal law claims. To this end, the Supreme Court in **Pilot**

Life acknowledged the development of a body of federal common law stemming from the regulatory scheme of ERISA. **107 S.Ct. at 1557-1558.**

Following this reasoning, the **Cedar Rapids Pediatric Clinic Pension Plan v. Continental Ins. Co., 690 F. Supp. 792, 795 (W.D. Ark. 1988)** court stated that the plaintiff's allegations as to common law claims based in breach of contract and negligence, state a claim under ERISA for breach of fiduciary duty. (See generally, **29 U.S.C. Sec. 1104(a)).** Although state common law claims are preempted under ERISA, and will be dismissed as state claims based upon **29 U.S.C. 1104(a)** the **Cedar Rapids** court however held it will "instead construe the plaintiff's common law allegations as descriptive claims that can be admittedly brought under ERISA." **690 F. Supp. at 795-796.**

As such, Jane Tomczyk's claim for breach of contract and tortious interference with contract is simply considered as a claim for breach of fiduciary duty under ERISA, **29 U.S.C. Sec. 1104(a).** This reasoning directly comports with the basic purpose or ERISA, to protect the rights and benefits of employees through a broad interpretation of federal and state remedies.

Without dispute, recoverability of extra-contractual damages in ERISA actions remain an unsettled area of law. **Vogel v. Independent Federal Savings Bank, 692 F. Supp. 587, 594 (D. Md. 198).** The **Vogel** court stated, following the Supreme Court ruling in **Massachusetts Mut'l Life Ins. Co. v. Russell, 105 S.Ct.**

* * * * *

UNITED STATES DISTRICT COURT
FOR THE SEVENTH CIRCUIT
Case No.: 91-1018

JANE TOMCZYK,

Plaintiff-Appellant,

v.

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant-Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN,
THE HONORALE ROBERT W. WARREN, PRESIDING, OF
DECISIONS AND ORDER GRANTING SUMMARY
JUDGMENT IN FAVOR OF THE DEFENDANT-APPELLEE.

APPELLANT'S REPLY BRIEF

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3741 West National Avenue
Milwaukee, WI 53215
(414) 649-9790

* * * * *

[p. 3] plan, they are directly affected by state laws that regulate insurance. **105 S.Ct. at 2395.** Blue Cross refuses

to address this analysis and makes the quantum leap that since this is an ERISA governed case, Wisconsin state law claims for bad faith and punitive damages are preempted. This quantum leap approach by Blue Cross simply is insufficient for Jane Tomczyk to address. Therefore, Jane Tomczyk respectfully requests this court to reverse the district court's ruling in preempting her state law claims for bad faith and punitive damages.

C. CONGRESS AND THE U.S. SUPREME COURT HAVE PROVIDED FOR THE DEVELOPMENT OF FEDERAL COMMON LAW CLAIMS AS THEY RELATE TO ERISA.

The Supreme Court stated in **Pilot Life Ins. Co. v. Dedeaux, 107 S.Ct. at 1557-1558,** that " "it is also intended that a body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans". The expectations that a federal common law of rights and obligations under ERISA regulate plans would develop, indeed, the entire comparison of **ERISA Sec. 502(A)** to **Sec. 301 of the LMRA,** would make little sense if the remedies available to ERISA participants and beneficiaries under **Sec. 502(a)** could be supplemented or supplanted by varying state laws."

> " "The legislative history demonstrates that Congress intended federal courts to develop federal common law in fashioning additional 'appropriate equitable relief.' In presenting the conference report to the full Senate, for example, Senator Javits, ranking minority member of Senate Committee on Labor and Public Welfare and one of the two principle Senate sponsors of ERISA, stated that "it is also intended that a body of federal substantive law will be developed by the courts [p. 4] to deal with issues involving

> rights and obligations under private welfare and pension plans." (Citation omitted). Senator Williams, the Committee's Chairman and the Act's other principle senator sponsor summarily emphasizes that suits involving beneficiary rights "will be regarded as arising under the laws of the United States, in similar fashion to those brought under **Sec. 301 of the Labor Management Relations Act.**" (Citation omitted). Sec. 301, of course, "authorizes federal courts to fashion a body of federal law" in contexts of collective bargaining agreements, to be derived by "looking at the policy of the legislation fashioning a remedy that will effectuate that policy." (Citation omitted). **Massachusetts Mut'l Life Ins. Co. v. Russell, 105 S.Ct. 3085, 3097-3098 (1985).**

Along with its ruling in **Pilot Life** and **Mackey v. Lanier Collections Agency & Service, 108 S.Ct. 2182, 2187 (1988),** the Supreme Court has recognized that the federal courts are requested to develop an area of federal common law under **Sec. 503(a) of ERISA.** This is the sole intent of Jane Tomczyk in pursuing an appeal for her claims for breach of contract, tortious interference with contract and extra-contractual damages.

Furthermore, this is not a claim for extra-contractual benefits under **29 U.S.C. Sec. 1132(a)(2).** These damages are precluded under **29 U.S.C. Sec. 1132(a)(2)** pursuant to **Massachusetts Mut'l Life Inc. Co. v. Russell, 105 S.Ct. 3085, 3094-3095 (1985).** A claim for extra-contractual damages, however, has not been precluded under **29 U.S.C. Sec. 1132(a)(1)(b) and (a)(3). 105 S.Ct. at** 3094-3095. It was Justice Brennan in **Russell** that stated, "thus while it may be that courts generally may not find implied private remedies in ERISA, the court's remarks have little bearing on how courts are

* * * * *

[DATED NOVEMBER 29, 1988]

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

JANE TOMCZYK,

Plaintiff,

v. Case No. 88-C-690

BLUE CROSS & BLUE SHIELD,
et al.,

Defendant.

AFFIDAVIT OF JOHN A. GOECKERMANN, D.D.S.

STATE OF WISCONSIN
MILWAUKEE COUNTY—ss

JOHN A. GOECKERMAN, D.D.S., being first duly sworn, on oath deposes and states that:

1. Your affiant is the treating physician of the plaintiff herein. That your affiant makes this affidavit on personal knowledge and in support of the plaintiff's brief in opposition to the defendants motion summary judgment.

2. That on September 30, 1987, your affiant's office contacted the defendant, Blue Cross, for the purpose of obtaining a preauthorization of the plaintiff's surgery. That a representative of the defendant, Blue Cross, stated that the plaintiff's insurance had authorized the hospital stay for the intended surgery.

3. That attached hereto and marked as Exhibit A is a true and correct copy of a letter your affiant sent to the defendant, Blue Cross. Said letter contains your affiant's diagnosis that the plaintiff required surgical care and that failure to have the necessary surgery would result in a malocclusion making it very difficult for the plaintiff to maintain a normal diet due to her inability to properly chew food for appropriate digestion. Moreover, said Exhibit A included the surgical fee and a cost breakdown of the treatment that the plaintiff would receive.

4. That on June 8, 1988 or June 9, 1988, your affiant received a telephone call from a representative of Blue Cross advising your affiant that the review board had reviewed Ms. Tomczyk's claim and decided that Blue Cross would not pay for the surgery because it was not a covered benefit. Your affiant asked the representative at that time if it was specifically stated in the policy that it was not a covered benefit. The representative of Blue Cross stated, "no" that they (Blue Cross) were just not paying the bill.

Dated this 29 day of November, 1988.

/s/ John A. Goeckerman, D.D.S.

[Notarization omitted in printing]

EXHIBIT A

(Letterhead Of)
DR. JOHN A. GOECKERMANN
4200 South 27th Street, Suite 102
Milwaukee, Wisconsin 53221

October 7, 1981

Blue Cross Blue Shield
P. O. Box 2141
Milwaukee, Wisconsin 53201

Re: Jane E. Tomczyk
0A0396647973

Gentlemen:

This letter is sent as a request for prior determination of benefits for Ms. Jane Tomczyk to undergo corrective surgery of a developmental skeletal deformity of her maxilla and mandible. Ms. Tomczyk presented to my office on 9/21/87 and was referred by Dr. Robert Schlamer for evaluation of the skeletal component of her maxillary and mandibular discrepancy and recommendation of a surgical treatment plan to correct this deformity. Ms. Tomczyk's chief complaint at the time of initial examination was difficulty with mastication and speech function as well as generalized maxillomandibular function.

Clinical examination shows vertical maxillary hyperplasia with mandibular retrognathia. There is misalignment of the posterior segments of the maxilla with those of the mandible and transverse maxillary deficiency is apparent. The discrepancy between maxillary and mandibular segmental alignment results in a malocclusion that makes mastication and assimilation of a normal diet very difficult.

Radiographic assessment shows vertical maxillary excess combined with mandibular retrognathia. The anteropos-

terior deficiency of the mandible is significant and correction of the discrepancy in this plane cannot be accomplished entirely with a maxillary osteotomy intrusion and autorotation of the mandible.

The surgical procedure required to correct Ms. Tomczyk's skeletal maxillary and mandibular deformity is a LeFort I segmental osteotomy intrusion and expansion of the maxilla combined with a sagittal split ramus osteotomy advancement of the mandible. The surgical fee for the LeFort I osteotomy with multiple sections is $3,400.00 and the surgical fee for the mandibular sagittal osteotomy is $2,200.00. In addition, due to the nature and complexity of the surgery a surgical assistant is required and his fee is typically twenty-five percent of the surgery fee. The procedure will required three to four days of hospitalization.

Please give consideration to this request for prior determination of benefits for Ms. Jane Tomczyk to undergo the intended corrective surgery of her maxilla and mandible. The purpose of this surgery is to provide her with a significant functional improvement so that she might be able to consume a more normal diet and function in a manner consistent with normal occlusion. If I may be of further assistance in clarification of the nature or purpose of the intended surgery, please feel free to contact me.

Sincerely,

John A. Goeckerman, D.D.S., M.S.

JAG/kal

Enclosure

Blue Cross & Blue Shield
United of Wisconsin

401 W Michigan St.
Milwaukee, WI 53201

JANE E TOMCZYK
3944 EAST IONA TERRACE
CUDAHY WI 53110

If you have any questions, please have your identification Number and Claim Number available and call or write:
LOCAL: 226-5163
IN-WIS: 1-800-242-9889
OUT-WIS: 1-800-558-7179 BOX# 2141

EXPLANATION OF BENEFITS

STATEMENT DATE 11/13/87

IDENTIFICATION NO.	CONTROL NUMBER
0A039-664-7973	0000106490053

SEE BACK OF FORM FOR EXPLANATION OF COLUMNS

PATIENT'S NAME / CLAIM NUMBER 1	PROVIDER'S NAME / DESCRIPTION OF SERVICES 2	DATES OF SERVICE 3	AMOUNT CHARGED 4	UCR DIFFERENCE 5	YOUR PORTION 6	REASON 7	AMOUNT PAID
JANE E TOMCZYK	J A BOECKERMAN DDS	10/21/87					
1187306-0231100	ORAL SURGERY PROCEDURE	10/21/87	40.00	.00	40.00	0	.00*
	ORAL SURGERY PROCEDURE	10/27/87	360.00	.00	360.00	0	.00*
	ORAL SURGERY PROCEDURE	10/27/87	90.00	.00	90.00	0	.00*
	TOTALS ----------		494.00	.00	494.00	.01	.00
1-WE ARE HAPPY TO BE OF SERVICE TO YOU.							

226-9915
+ lic 8-7
9-30-87

Exhibit "A"

*Payment of this claim has been made to provider

FDSN 926807242 REFERENCE NO: 926808039664797 3 TOTAL 494.00 .00 494.00 .00

BEST AVAILABLE COPY

EXHIBIT C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

JANE TOMCZYK,

Plaintiff,

vs. Case No. 88-C-690

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant.

AFFIDAVIT OF ELISE McKINCH, R.N., B.S.

STATE OF WISCONSIN
COUNTY OF MILWAUKEE—ss

Elise McKinch, R.N., B.S. being first duly sworn, does hereby depose and state that:

1. She is employed by Blue Cross & Blue Shield United of Wisconsin (Blue Cross), 401 West Michigan Street, Milwaukee, Wisconsin, in the position of Managed Care Specialist. She has been so employed since May of 1987.

2. In her capacity as Managed Care Specialist she reviews inpatient hospital admissions and authorizes lengths of stay in connection with Blue Cross' managed care program, also known as the Advantage Program

3. In the course of performing these duties, she electronically documents all information relevant to the inpatient authorizations. She enters into a computer all infor-

mation on the patient's membership, eligibility, the request for admission, and the necessity of a second opinion. She also enters summaries of her conversations with the patient and the provider. By retrieving this electronically stored information, she was able to reconstruct the conversation described below.

4. On September 30, 1987, a "Kathy" from Dr. John Goeckermann's office telephoned Blue Cross' Advantage Program to get a preauthorization of an inpatient hospital admission for Blue Cross subscriber Jane Tomczyk. I took this telephone call. The caller informed me that the surgery necessitating the stay was a Lefort I osteotomy and a Sagittla Split Ramus osteotomy. Because jaw and mouth surgery is only covered in limited instances under Blue Cross contracts, I knew that coverage of the proposed surgical procedures was questionable. I instructed the caller that it would be advisable to get verification of coverage from Blue Cross' Medical Review department. I informed the caller that I would authorize a three day inpatient hospital stay. I informed the caller that the authorization related to the patient's need to have the procedures done as an inpatient and was not an authorization of coverage. The caller said that she would send a request to Blue Cross' Medical Review department for a preauthorization of coverage for the surgical procedures.

5. Because I had determined, and informed the caller, that medical review was necessary, I did not send Dr. Goeckermann's office the customary letter of confirmation of the inpatient admission preauthorization.

/s/ Elise M. McKinch
Elise McKinch
Affiant

[Notarization omitted in printing]

THE MILWAUKEE SENTINEL—January 3, 1992

Federal court penalizes law firm $2,000 for frivolous appeal

By TANNETTE JOHNSON-ELIE
Sentinel staff writer

A Milwaukee law firm has been ordered to pay $2,000 in sanctions by the 7th U.S. Court of Appeals for bringing a frivolous appeal.

In its decision returned Thursday, the 7th Circuit ruled that there was no reasonable basis for an appeal brought by attorneys Marjan Kmiec and Christopher McConville of the Kmiec Law Offices.

The court imposed Rule 38 sanctions, which authorize penalties for frivolous appeals.

The case involved a dispute over health care benefits involving Jane Tomczyk, of Cudahy, and Blue Cross & Blue Shield United of Wisconsin.

Tomczyk sued Blue Cross in Federal Court in 1987, charging that the insurer acted in bad faith by denying her reimbursement of $8,250 in surgical and hospital fees.

The suit alleged that Blue Cross violated the Employee Retirement Income Security Act, a federal law that regulates insurance and other employee benefits.

Tomczyk, who was employed by First Financial Savings Association, underwent oral surgery in 1987 and filed a claim with Blue Cross, which denied it.

Her suit was dismissed by Federal Judge Robert W. Warren, who ruled that the surgery was not covered under her health insurance plan with Blue Cross.

Tomczyk appealed the decision, and her attorneys have been ordered to pay the expenses of Blue Cross in defending the appeal.

The 7th Circuit issues a scathing criticism of Kmiec and McConville, charging that cases they cited to support Tomczyk's claims were irrelevant.

"When the law disfavored Tomczyk's case, it was ignored, glossed over or misstated," the 7th Circuit wrote. "Puffery was proffered as fact.

"Her attorneys represented the record in a thoroughly misleading and unprofessional fashion, further demonstrating frivolousness."

The appeals court rejected McConville's argument that Blue Cross authorized Tomczyk's hospital stay, which entitled her to coverage of medical expenses.

McConville, however, defended his position when contacted Thursday.

"The doctor received the OK by Blue Cross to go ahead and perform the surgery," McConville said. "I still think it's a valid argument."

McConville said the case has been damaging to Tomczyk, who filed for bankruptcy.

"The poor lady can't afford to pay the medical bills that Blue Cross was supposed to pay," McConville said.

Laurel Barnes, assistant general counsel for Blue Cross, said she was not surprised by the appeals court decision.

"I expected it to come down the way it did," Barnes said. "This is good for insurers and people covered by employee benefit plans because when you figure punitive damages into the health care cost equation, you inject unpredictability into health care and it's expensive enough."

McConville said the decision sends a negative message to consumers. "It says you don't have rights under the federal law."

Supreme Court, U.S.
FILED
MAY 1 1992
OFFICE OF THE CLERK

(2)

No. 91-1578

In The
Supreme Court of the United States
OCTOBER TERM, 1991

JANE TOMCZYK,

Petitioner,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court of Appeals For the Seventh Circuit

BRIEF OF RESPONDENT IN OPPOSITION TO PETITION FOR CERTIORARI

Elizabeth Bartlett
Assistant Counsel
Blue Cross & Blue Shield
United of Wisconsin
401 West Michigan Street
Milwaukee, WI 53201-2025
(414) 226-6777
Attorney for Respondent

82

COUNTER STATEMENT OF THE QUESTION PRESENTED FOR REVIEW

1. Should the Courts grant and affirm a motion for summary judgment where the pleadings and other documents of record in the case show that there are no material facts in dispute and that the moving party is entitled to judgment as a matter of law?

RULE 29.1 LIST

Blue Cross & Blue Shield United of Wisconsin (Blue Cross) has no parent company. It holds a controlling interest in the following companies which are not wholly-owned subsidiaries: United Wisconsin Services, Inc.

TABLE OF CONTENTS

COUNTER STATEMENT OF THE QUESTION PRESENTED FOR REVIEW i

RULE 29.1 LIST ii

TABLE OF AUTHORITIES iv

OPINIONS BELOW 2

COUNTER STATEMENT OF THE CASE 2

REASONS FOR DENYING THE WRIT 5

I. The Petitioner Has Failed To Show Special And Important Reasons For Granting Certiorari. 5

A. The Record In This Case Supports The District Court's And Court Of Appeals' Independent Conclusions That No Material Facts Are In Dispute And That Summary Judgment Was Appropriate. 6

B. The District Court And Court Of Appeals Correctly Concluded That Petitioner's Claims For Extracontractual Damages, Including Her Claim Of Bad Faith, Are Preempted by Federal Law. 8

C. The Imposition Of Sanctions On Petitioner's Counsel Does Not Constitute A Special Or Important Reason For Granting A Writ. 16

CONCLUSION 18

TABLE OF AUTHORITIES

Cases	Page
Anderson v. Continental Ins. Co., 85 Wis. 2d 675, 271 N.W. 2d 368 (1978)	9, 10
Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986)	6
Bishop v. Osborn Transportation, 838 F.2d 1173 (11th Cir. 1988) *cert. denied* 488 U.S. 832 (1988)	13
Dependahl v. Falstaff Brewing Co., 653 F. 2d 1208 (8th Cir. 1981) *cert. denied* 454 U.S. 968 (1981)	13
Docter v. Furch, 91 Wis. 464, 65 N.W. 161 (1895)	11
Drinkwater v. Metropolitan Life Ins. Co., 846 F. 2d 821 (1st Cir. 1988) *cert. denied* 488 U.S. 909 (1988)	13, 14
Eaton v. Blue Cross & Blue Shield of Ala., 681 F. Supp. 759 (S.D. Ala. 1988)	14
FMC Corp. v. Holliday, 111 S. Ct. 403 (1990)	15, 16
In Re Estate of Chayka, 47 Wis. 2d 102, 176 N.W. 2d 561 (1970)	11
Kleinhans v. Lisle Savings Profit Sharing Trust, 810 F. 2d 618 (7th Cir. 1987)	13, 14

Koller v. Blue Cross & Blue Shield United of Wisconsin, et al., No. 87-C-903 (E.D. Wis. Jan. 29, 1991) 17

Maciosek v. Blue Cross & Blue Shield United of Wisconsin, 930 F. 2d 536 (7th Cir. 1991) 12, 13, 17

Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985) 11

McGrew v. Blue Cross & Blue Shield United of Wisconsin, et al., No. 87-C-1224 (E.D. Wis. Oct. 7, 1988) 17

Meyer v. Employers Health Ins. Co., 722 F. Supp. 547 (E.D. Wis. 1989) 10, 17

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987)... 9, 11, 12

Powell v. Chesapeake and Potomoc Tel. Co., 780 F. 2d 419 (4th Cir. 1985) *cert. denied* 476 U.S. 1170 (1986).. 13

Reilly v. Blue Cross & Blue Shield United of Wisconsin, 846 F. 2d 416 (7th Cir. 1988) *cert. denied* 488 U.S. 856 (1988) 13

Rice v. Sioux City Cemetery, 349 U.S. 70 (1955) 6

Robinson v. Blue Cross & Blue Shield United of Wisconsin, et al., No. 88-C-0435 (E.D. Wis. Apr. 5, 1991) 17

Rust v. Blue Cross & Blue Shield United of Wisconsin, et al, 1988 U.S. Dist. LEXIS 17207 (E.D. Wis. Sept. 21, 1988) 9, 10, 17

Smith v. Blue Cross & Blue Shield United of Wisconsin, et al., 724 F. Supp. 618 (E.D. Wis. 1989) 17

Smith v. Blue Cross & Blue Shield United of Wisconsin, et al., 1992 U.S. App. LEXIS 5497 (E.D. Wis. March 27, 1992) 17

Sokol v. Bernstein, 803 F. 2d 532 (9th Cir. 1986) 13

Sommers Drug Stores Co. v. Corrigan Enterprises, 793 F. 2d 1456 (5th Cir. 1986), cert. denied, 479 U.S. 1034 and 1089 (1987) 13

Varhola v. Doe, 820 F. 2d 809 (6th Cir. 1987) 13

OTHER AUTHORITIES

29 U.S.C. § 1132 (a) (3) 11, 13, 15

42 U.S.C. § 1983 4

Fed. R. App. P. 38 5

Sup. Ct. R. 10 6

Fed. R. Civ. P. 56 (c) and (e) 6

Wisconsin Pattern Jury Instruction 3044 ..... 10, 11

ERISA § 502 (a) (1) (B) 12

S. Rep. No. 383, 93d Cong., 2d Sess. (1974) 14, 15

No. 91-1578

In The
Supreme Court of the United States
OCTOBER TERM, 1991

JANE TOMCZYK,

Petitioner,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court of Appeals For the Seventh Circuit

BRIEF OF RESPONDENT IN OPPOSITION TO PETITION FOR CERTIORARI

The Respondent Blue Cross & Blue Shield United of Wisconsin (Blue Cross), by its undersigned counsel, respectfully requests this Court to deny the Petition for a writ of certiorari to the United States Court of Appeals for the Seventh Circuit for review of the judgment in *Tomczyk v. Blue Cross & Blue Shield United of Wisconsin*, Case No. 91-1018, December 30, 1991.

OPINIONS BELOW

The Petitioner seeks a writ of certiorari from an opinion of the United States Court of Appeals For The Seventh Circuit decided on December 30, 1991, *Tomczyk v. Blue Cross & Blue Shield United of Wisconsin, Case No. 91-1018,* which affirmed a Decision and Order of the United States District Court, Eastern District of Wisconsin, entered on May 8, 1989, *Tomczyk v. Blue Cross & Blue Shield United of Wisconsin,* 715 F. Supp. 914 (E.D. Wis. 1989).

COUNTER STATEMENT OF THE CASE

Contrary to the impression conveyed by the Petition, the opposing affidavits in this case upon which the District Court and Court of Appeals based their decisions granting and affirming summary judgment for Blue Cross are not in conflict, and the district and appellate courts below did not inappropriately shift any burdens to Petitioner in ruling on the motion for summary judgment. Moreover, controlling precedent clearly dictated dismissal of Tomczyk's claims for extracontractual damages.

Petitioner Tomczyk was a member of an ERISA regulated group health insurance plan issued by Blue Cross and sponsored by her employer. Tomczyk's insurance through Blue Cross was subject to the Blue Cross "Advantage Program." Under this program, certain requirements must be met before a plan member may receive full benefits for covered services for non-emergency inpatient hospital care. The member must notify Blue Cross prior to an admission that hospitalization is anticipated. Blue Cross

then determines whether the inpatient hospitalization is medically necessary, and authorizes the admission and a length of stay. The insurance contract provides that "[i]f the admission was not preauthorized, benefits will be limited to 80% of the amount otherwise allowed according to the contract provisions for covered benefits." The contract further states that even where the hospital stay is preauthorized, "[o]ther limitations, exclusions and conditions of the contract are not affected by this section and still apply."

Tomczyk first consulted with John Goeckermann, D.D.S., who subsequently performed surgery on her jaw, on September 21, 1987. Goeckermann determined that Tomczyk required corrective treatment consisting of two variations of an oral surgical procedure known as "osteotomy of the temporo mandibular joint." On September 30, 1987, an employee of Goeckermann's office called Blue Cross' Advantage Program and spoke to Elise McKinch, R.N., a Managed Care Specialist, who reviews the medical necessity of inpatient hospital admissions and authorizes lengths of stay.

McKinch determined whether the proposed services were most appropriately performed as inpatient, or whether they could be performed on an outpatient basis. McKinch informed Goeckermann's office that Blue Cross "would authorize a three day inpatient hospital stay" for Tomczyk. She also informed Goeckermann's office "that the authorization related to the patient's need to have the procedures done as an inpatient and was not an authorization of coverage." She also stated that "it would be advisable to get verification of coverage from Blue Cross' Medical

Review Department." Because she had determined, and informed Goeckermann's office, that the procedure might not be a covered benefit, she did not send the customary letter confirming preauthorization of the hospital stay.

On October 12, 1987, Blue Cross received a letter from Goeckermann dated October 7, seeking "prior determination of benefits for the proposed surgery." Blue Cross never indicated that the surgery was a covered benefit.

After undergoing the oral surgery in late October of 1987, Tomczyk filed a claim with Blue Cross for reimbursement of approximately $8,250 in medical expenses. Blue Cross denied the claim because the type of surgery performed was not a covered benefit of the plan. Tomczyk then sued Blue Cross under ERISA for denial of contract benefits and in addition, brought state common-law claims of bad faith, breach of contract, tortious interference with her contractual relationship with her doctor and asserted a constitutional claim under 42 U.S.C. § 1983. Blue Cross moved for summary dismissal of all claims.

The District Court dismissed the state common-law claims as preempted by ERISA, and the § 1983 claim owing to a lack of state action. In a separate decision granting Blue Cross summary judgment on the ERISA claim, the court determined that no genuine issue of material fact existed and found that Blue Cross had properly denied benefits to Tomczyk under the terms of the contract. Tomczyk appealed the grant of summary judgment to Blue Cross on the ERISA claim, and the dismissal of her state common law and extra-contractual damage claims.

In her appeal, Tomczyk did not dispute the District

Court's finding that her surgery was not covered under the insurance plan. Rather, she claimed that the court should not have granted summary judgment because there was a disputed factual issue concerning whether Blue Cross had verbally verified payment of her medical expenses.

The Court of Appeals, like the District Court, found no disputed issue of material fact in evidence, and affirmed the District Court's grant of summary judgment to Blue Cross on the ERISA claim. The Court of Appeals also affirmed the District Court's dismissal of Tomczyk's state common-law extracontractual damage claims.

In rendering its decision, the Court of Appeals found that "misrepresentations of controlling law and disingenuous arguments . . . were mainstays of Tomczyk's brief. . . . when the law disfavored Tomczyk's case it was ignored, glossed over, or misstated. Puffery was proffered as fact. Her attorneys presented the record in a thoroughly misleading and unprofessional fashion. . . demonstrating frivolousness." For these reasons, the Court of Appeals imposed sanctions upon Tomczyk's counsel pursuant to Rule 38 of the Federal Rules of Appellate Procedure.

REASONS FOR DENYING THE WRIT

I. The Petitioner Has Failed To Show Special And Important Reasons For Granting Certiorari.

> "Special and important reasons" for granting Supreme Court review "imply a reach to a problem beyond the academic or the episodic...[I]t is very important that we be consistent in not granting the writ of certiorari except in cases involving principles the settlement of which is of importance to the

public as distinguished from that of the parties."

Rice v. Sioux City Cemetery, 349 U.S. 70, 74, 79 (1955) (citations omitted).

Petitioner's true motivation for filing the Petition in this case can be summed up by a phrase quoted from the Petition itself; "Tomczyk, and her counsel . . . petition this court . . . with the hopeful restitution of their reputation." Pet. p. 8. A review of the Petition quickly reveals it is not based upon the merits of the case itself. Rather, it represents an effort on the part of Petitioner's counsel to restore his reputation in the legal community. Just like all of the briefs and oral arguments which have gone before by this law firm against this and other insurance company defendants, however, the Petition contains mischaracterizations and misstatements of the facts and law, and frivolous arguments which ignore controlling precedent. The Petition fails to demonstrate that any of the considerations of Rule 10 of the Supreme Court Rules governing Petitions for Certiorari are met.

A. The Record In This Case Supports The District Court's And Court Of Appeals' Independent Conclusions That No Material Facts Are In Dispute And That Summary Judgment Was Appropriate.

When a motion for summary judgment is made and supported by affidavits demonstrating a prima facie case for summary judgment, the non-moving party must, by affidavits or otherwise, set forth specific facts showing that there is a genuine issue for trial. Fed. R. Civ. P. 56 (c) and (e). To defeat a properly supported motion, the nonmoving party must produce sufficient evidence for a jury to return a verdict in his favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242,

249 (1986). Petitioner claims that her case was subjected to "trial by affidavit" and that "reasonable inferences" were resolved against her, contrary to the summary judgment standards. The record, however, demonstrates that such was not the case.

The evidence presented by Tomczyk to oppose Blue Cross' motion for summary judgment does not contradict and in fact confirms the account given by McKinch in an affidavit submitted by Blue Cross. Tomczyk presented an affidavit from Goeckermann, wherein he states that McKinch told his office that Blue Cross "had authorized the *hospital stay* for the intended surgery." (emphasis added). The McKinch affidavit also states that she informed Goeckermann's office on September 30, 1987 that Blue Cross had authorized the *hospital stay* for the intended surgery. Pet. App. 44 and 49. The McKinch and Goeckermann affidavits are in accord. Goeckermann's affidavit does not refute McKinch's account that she further informed his office that verification of benefits for the surgery itself must be obtained from Blue Cross' Medical Review Department. Pet. App. 44. In fact, Goeckermann's subsequent actions confirm McKinch's account in this regard, in that seven days later, Goeckermann sent a letter to Blue Cross "request[ing] a prior determination of benefits for . . . Tomczyk . . ." Pet. App. 46.

Petitioner argues that the court below violated the standards for summary judgment by not inferring from Goeckermann's affidavit and his October 7 letter that Blue Cross preauthorized *both* the hospital stay *and* verified benefits for the surgical procedure in the September 30 phone conversation with McKinch. Pet. pp. 10-11. This argument is truly a non-sequitur.

The affidavits are clear on their face and speak for themselves. Had Goeckermann intended to say that he believed benefits for the surgery itself had been verified, one must presume he would have used words that expressed that it was the "surgery" that was authorized, not the "hospital stay." Moreover, it is obvious that it would make no sense for Goeckermann to subsequently request a verification of benefits for Tomczyk's surgery if, as Petitioner contends, Goeckermann believed his office had already received such verification from McKinch on September 30.[1] The affidavits on file show no material issue of fact in dispute. There were no reasonable inferences to be drawn in Tomczyk's favor, and the Court of Appeals did not err by affirming the District Court's grant of summary judgment in favor of Blue Cross on Tomczyk's ERISA claim.

B. The District Court And Court Of Appeals Correctly Concluded That Petitioner's Claims For Extracontractual Damages, Including Her Claim Of Bad Faith, Are Preempted by Federal Law.

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[1] Petitioner attempts to muddy the issues by contending that the Court of Appeals erred in identifying the date of Tomczyk's surgery as October 3, rather than October 27, 1987. In any event, the date of the surgery is not a material fact. The material and still undisputed fact is that Goeckermann submitted the verification request regarding the surgery to Blue Cross *after* McKinch spoke with his office. The only reasonable inference to be drawn from this fact is that he did not believe benefits for the surgery had already been verified in the September 30 telephone conversation with McKinch.

Bad Faith Claim

Controlling precedent is clear: Tomczyk's state law claim for bad faith is preempted by ERISA. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49-57 (1987), this Court held that Mississippi's state law tort of bad faith is preempted and not saved by ERISA. Relying on the analysis in *Pilot Life*, the Federal District Court for the Eastern District of Wisconsin ruled that the Wisconsin law of bad faith is preempted. *See Rust v. Blue Cross & Blue Shield United of Wisconsin, et al.*, 1988 U.S. Dist. LEXIS 17207 at 11-12 (E.D. Wis. Sept. 21, 1988). Res. App. 1, 9-10. Citing *Pilot Life*, the District Court in *Rust* held:

> In *Anderson v. Continental Insurance Company*, 85 Wis. 2d 675, 689, 271 N.W.2d 368, 375 (1978), the Wisconsin Supreme Court stated that "*every* contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." (Emphasis added.) Thus, since the Wisconsin tort applies to "every contract," not just insurance contracts, bad faith would not meet the requirements of the savings clause under either a common-sense understanding of the phrase "regulates insurance," *see* 107 S. Ct. at 1554, or under an examination of whether the tort is limited to the insurance industry. Furthermore, the tort of bad faith cannot be said to have an impact on the spreading of policyholder risk, nor is the tort an integral part of the relationship between insured and an insurer. *See Pilot Life*, at 1554-1555 (bad faith tort applies no differently to insurance contract than any other contract). In sum, the analysis of the Wisconsin bad faith tort is almost identical to that of the Supreme Court on Mississippi's bad faith tort. The conclusions certainly are: the Court finds the Wisconsin tort of bad faith is pre-empted by ERISA."

Id.

In affirming the dismissal of Tomczyk's bad faith claim, the Court of Appeals noted with grave concern the fact that in the appellate brief, her counsel failed to cite *Rust* and another controlling case on the question of preemption of other common law tort claims, *Meyer v. Employers Health Ins. Co.*, 722 F. Supp. 547, 552-53 (E.D. Wis. 1989). (claims for breach of contract, tortious interference with contract, and intentional infliction of emotional distress preempted by ERISA). The Court of Appeals found these omissions particularly disturbing in that Tomczyk's counsel had also been plaintiff's counsel in the *Rust* and *Meyer* cases.

Despite the existence of the controlling precedent cited above and the Court of Appeals' imposition of sanctions, Petitioner still persists in arguing that Wisconsin bad faith is a law regulating insurance and thus saved from ERISA preemption. Once again, Petitioner's counsel does not even acknowledge, much less attempt to distinguish or discuss the *Rust* and *Meyer* cases.

As support for the argument that Wisconsin bad faith law is saved from preemption, Petitioner once again cites *Anderson v. Continental Ins. Co.*, despite its clear holding that "*every* contract imposes upon each party a duty of good faith and fair dealing." 271 N.W.2d 368, 375, 85 Wis. 2d 675, 689 (1978) (emphasis added) Petitioner also cites Wisconsin Pattern Jury Instructions on bad faith as support for the erroneous contention that bad faith is exclusive to insurance cases.

Petitioner, however, fails to cite Wisconsin Pattern Jury Instruction 3044, "Good Faith." Res. App. 12. The Good

Faith instruction begins "Every contract implies good faith and fair dealing between the parties . . ." If a duty of good faith exists in every contract, that duty is capable of being breached. Breach of the duty of good faith surely means that a party has acted in bad faith, and damages may flow therefrom. Nowhere does Instruction 3044 state that it is limited to insurance cases. The instruction cites several authorities, including *In Re Estate of Chayka*, 47 Wis. 2d 102, 107, 176 N.W.2d 561, 564 (1970) (duty of good faith is implied condition in every contract, including a contract to make a joint will) and *Docter v. Furch*, 91 Wis. 464, 476-77, 65 N.W. 161, 164 (1895) (duty of good faith in contract to convey land).

Petitioner's argument that bad faith principles have been applied by Wisconsin courts in numerous insurance cases, but not specifically in employment cases fails to demonstrate that bad faith is a law solely regulating insurance and therefore saved from ERISA preemption. Petitioner provides no substantive refutation of the sound reasoning of *Pilot Life* followed by the *Rust* court, which was adhered to by the Court of Appeals in *Tomczyk*.

Other Extracontractual Damage Claims

While this Court in *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) expressly reserved judgment on whether extracontractual damages could be had under 29 U.S.C.§ 1132 (a) (3) (providing for "other equitable relief") the decision in *Russell* contains strong dicta to the effect that ERISA was not intended to provide extracontractual damages under *any* of its provisions.

> "Significantly, the statutory provision explicitly authorizing a beneficiary to bring an action to enforce his rights under

> the plan - §502 (a) (1) (B),...says nothing about the recovery of extracontractual damages, or about the possible consequences of delay in the plan administrator's processing of a disputed claim. Thus, there is really nothing at all in the statutory text to support the conclusion that such a delay gives rise to a private right of action for compensatory or punitive relief."

Id. at 144.

> "The six carefully integrated civil enforcement provisions found in §502 (a) of the statute as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."

Id. at 146 (emphasis in original).

The Seventh Circuit Court of Appeals has likewise ruled that state law tort and contract claims may not be maintained against insurers of employee benefit plans. *See Maciosek v. Blue Cross & Blue Shield United of Wisconsin*, 930 F.2d 536 (7th Cir. 1991). In *Maciosek*, an action involving the denial of benefits under a health plan, the Seventh Circuit upheld the District Court's determination that the plaintiffs' claims for breach of contract, tortious interference with contract and intentional infliction of emotional distress under Wisconsin common law were preempted by ERISA. The Court rejected the plaintiffs' argument that these claims were "saved" from preemption because they were based on laws regulating insurance:

> "These claims do not qualify for the savings clause under any of the factors listed by the Supreme Court in *Pilot Life* . . . They do not specifically impact the insurance industry, but are laws of general application. Nor are they part of the "business

> of insurance" under the McCarran-Ferguson Act. Further, ERISA's civil enforcement scheme was designed to provide a remedy for these types of alleged wrongs . . . Finally, the claim is based on a circumstance—a dispute over employee insurance benefits—that the civil enforcement provisions of ERISA were designed to remedy. The district court properly held these claims preempted by ERISA."

Maciosek, 930 F.2d at 540 (citations omitted). See also *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416, 418 (7th Cir. 1988) *cert. denied* 488 U.S. 856 (1988)[2] and *Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987) (punitive damages unavailable).

The majority of other federal appellate courts which have considered this question have also rejected extra-contractual damages as a remedy under § 1132(a)(3). See *Bishop v. Osborn Transportation*, 838 F.2d 1173, 1174 (11th Cir. 1988) *cert. denied* 488 U.S. 832 (1988); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821, 824-825 (1st Cir. 1988) *cert. denied* 488 U.S. 909 (1988); *Varhola v. Doe*, 820 F.2d 809, 817 (6th Cir. 1987); *Sokol v. Bernstein*, 803 F.2d 532, 534-537 (9th Cir. 1986); *Sommers Drug Stores Co. v. Corrigan Enterprises*, 793 F.2d 1456, 1462-65 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 and 1089 (1987); *Powell v. Chesapeake and Potomoc Tel. Co.*, 780 F.2d 419, 424 (4th Cir. 1985), *cert. denied* 476 U.S. 1170 (1986); *Dependahl v. Falstaff Brewing Co.*, 653 F.2d 1208, 1216 (8th Cir. 1981) (dictum), *cert. denied* 454 U.S. 968 (1981).

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[2] Petitioner's Counsel was also counsel for the plaintiff in *Maciosek* and *Reilly*.

As the First Circuit said in *Drinkwater*, "'other appropriate equitable relief' should be interpreted to mean what it says—declaratory or injunctive relief, not compensatory and punitive damages." 846 F.2d at 824. "Equitable" relief implies relief that will make a person whole by restoring to him or her that to which he or she is entitled. It does not imply compensatory damages for inconvenience, worry, or emotional distress, or punitive damages designed to punish the plan administrator. *Eaton v. Blue Cross & Blue Shield of Ala.*, 681 F. Supp. 759, 762 (S.D. Ala. 1988). The legislative history of ERISA indicates that Congress intended to import to ERISA the fiduciary principles of trust law. *Id.*; *See also Kleinhans*, 810 F.2d at 627.

As the Ninth Circuit said in *Sokol*, "[p]erhaps the most telling indication of what congress meant by 'appropriate equitable relief' appears in the Senate Finance Committee report on ERISA:"

> "Appropriate equitable relief may be granted in a civil action. For example, injunctions may be granted to prevent a violation of fiduciary duty, and a constructive trust may be imposed on the plan assets, if needed to protect the participants and beneficiaries. Also, the bill specifically provides that a fiduciary may be removed through civil action brought by the Secretary or participants or beneficiaries if he has violated any of the specified fiduciary obligations. . . It is expected that a fiduciary. . . may be removed for repeated or substantial violations of his responsibilities, and that upon removal the court may, in its discretion, appoint someone to serve until a fiduciary is properly chosen in accordance with the plan."

803 F.2d at 538, (quoting S. Rep. No. 383, 93d Cong., 2d

Sess., *reprinted in* 1974 U.S. Code Cong. & Ad. News 4890, 4989). The above passage illustrates Congress' intent to afford such remedies as injunctive relief, constructive trust, and removal of the fiduciary. Thus, it appears that "Congress used the word 'equitable' to mean what it usually means—injunctive or declaratory relief." *Id.* (footnote omitted). The clear weight of authority holds that "equitable relief" under 29 U.S.C. §1132(a)(3) does not include extracontractual damages for plan beneficiaries.

Petitioner devotes the balance of the discussion on her extracontractual damage claims to arguing that state laws solely regulating insurance are saved from preemption and thus may be applied to insured ERISA plans. Respondent readily concedes this well established point. Respondent further readily concedes that the plan covering Tomczyk was an insured plan, subject to state insurance laws. However, in light of the fact that none of Tomczyk's common law claims are based on state laws solely regulating insurance, and therefore are not saved from preemption, her discussion of this point is wholly tangential.[3] The Court of Appeals

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[3] Apparently continuing the pattern observed by the Court of Appeals, Petitioner misstates the law. Petitioner asserts that *FMC Corp. v. Holliday*, 111 S. Ct. 403, 409 (1990) held that "the deemer clause *does not* exempt self-funded ERISA plans from state laws that regulate insurance within the meaning of the savings clause." Pet. at p. 14, emphasis added. In fact, *FMC* held precisely the opposite:

> "By forbidding States to deem employee benefit plans 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves plans from state laws 'purporting to regulate insurance.' As a result, self-funded

(Footnote continued on following page)

correctly affirmed the ruling of the District Court that Tomczyk's claims for extracontractual damages are preempted by ERISA.

C. The Imposition Of Sanctions On Petitioner's Counsel Does Not Constitute A Special Or Important Reason For Granting A Writ.

Tomczyk's counsel "implores" the Court to allow him the opportunity to "address the complexity of ERISA's . . . clauses and the ongoing dynamics of ERISA remedies." Pet. at p. 20. However, Tomczyk's counsel has been doing just that for years. The manner in which counsel has proceeded, however, does not justify further opportunity to tilt at windmills. The arguments advanced in proceedings below in this case are the same arguments that have been repeatedly advanced by this same counsel, often against this same defendant; arguments that have been consistently rejected by

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[3] Continued

> ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not 'saved' because they do not regulate insurance. *State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws."*

FMC at 409, emphasis added.

the District Courts and the Court of Appeals of this circuit. *See Rust* and *Meyers* supra at pp. 9-10 of this brief; *Smith v. Blue Cross & Blue Shield United of Wisconsin, et al.*, 724 F. Supp. 618 (E.D. Wis. 1989)[4]; *Maciosek v. Blue Cross & Blue Shield United of Wisconsin*, 930 F.2d 536 (7th Cir. 1991); *Robinson v. Blue Cross & Blue Shield United of Wisconsin, et al.*, No. 88-C-0435 (E.D. Wis. Apr. 5, 1991), Res. App. 13-14; *Koller v. Blue Cross & Blue Shield United of Wisconsin, et al.*, No. 87-C-903 (E.D. Wis. Jan. 29, 1991), Res. App. 15, 20-24, 28-30; *McGrew v. Blue Cross, et al.*, No. 87-C-1224 (E.D. Wis. Oct. 7, 1988), Res. App. 31-35.

The Petition presents no justification for allowing Tomczyk's counsel an opportunity to restate to this Court arguments which have been repeatedly and soundly rejected by the lower courts, and which fly in the face of controlling precedent, including numerous decisions of this Court.

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[4] The Seventh Circuit affirmed the District Court's ruling in *Smith* on March 27, 1992. See *Smith v. Blue Cross & Blue Shield United of Wisconsin, et al.*, 1992 U.S. App. LEXIS 5497. Res. App. 40-55.

CONCLUSION

Petitioner has failed to demonstrate special and important reasons for granting certiorari. For the reasons stated in this response and upon the rationale of the lower court decisions, respondent respectfully requests that the Petition for Writ of Certiorari be denied.

Respectfully submitted, April 1992.

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RESPONDENT'S

APPENDIX

INDEX TO RESPONDENT'S APPENDIX

Rust v. Blue Cross & Blue Shield United of Wisconsin, et al., 1988 U.S. Dist. LEXIS 17207 (E.D. Wis. Sept. 21, 1988)..... Res. App. 1

Wisconsin Pattern Jury Instruction 3044..... Res. App. 12

Robinson v. Blue Cross & Blue Shield United of Wisconsin, et al., No. 88-C-0435 (E.D. Wis. Apr. 5, 1991)..... Res. App. 13

Koller v. Blue Cross & Blue Shield United of Wisconsin, et al., No. 87-C-903 (E.D. Wis. Jan. 29, 1991)..... Res. App. 15

McGrew v. Blue Cross & Blue Shield United of Wisconsin, et al., No. 87-C-1224 (E.D. Wis. Oct. 7, 1988)..... Res. App. 31

Smith v. Blue Cross & Blue Shield United of Wisconsin, et al., 1992 U.S. App. LEXIS 5497 (E.D. Wis. March 27, 1992)..... Res. App. 40

Res. App. 1

Case No. 87-C-0751

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
September 21, 1988, Decided and Filed

AMY RUST,

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and WISCONSIN BELL, INCORPORATED,

Defendants.

OPINION BY: [*1]
WARREN
OPINION: DECISION AND ORDER
ROBERT W. WARREN,
UNITED STATES DISTRICT JUDGE

Plaintiff Amy Rust brought suit against defendants Blue Cross and Blue Shield United of Wisconsin, Wisconsin Bell, Inc., Mid-America Mutual Life Insurance Company and Francis Orval for damages allegedly arising out of her failure to receive insurance benefits following her divorce. Plaintiff alleged claims against Blue Cross for (1) bad faith, (2) economic duress, and (3) emotional distress; against Blue Cross and Wisconsin Bell, jointly, for (4) conspiracy; and against Mid-America for (5) breach of contract, (6) negligent misrepresentation, (7) bad faith, and (8) emotional distress.

Plaintiff sought compensatory and punitive damages.

Presently pending before the court is a joint motion by defendants Blue Cross and Wisconsin Bell for summary judgment. Defendants Blue Cross and Wisconsin Bell also have moved to strike plaintiff's jury demand.

I. BACKGROUND

A. Procedural History

Amy Rust brought suit in Milwaukee County Circuit Court on May 28, 1987. The case was removed to this court on June 19, 1987, by Wisconsin Bell pursuant to 28 U.S.C. § 1441. In a Stipulation and Order dated September 25, 1987, [*2] Mid-America and Francis Orval were dismissed from the case, leaving only the claims against Blue Cross and Wisconsin Bell.

The bad faith claim against Blue Cross alleged that Blue Cross refused to allow plaintiff to convert her health insurance group plan following her divorce. The Economic duress claim alleged that Blue Cross knew of plaintiff's difficult financial condition and attempted to use that knowledge to get plaintiff to abandon her rights. This conduct also allegedly caused plaintiff severe emotional distress, another claim. The conspiracy claim alleged that Blue Cross and Wisconsin Bell conspired to deprive plaintiff of her right to conversion of the medical plan.

At a status conference held November 16, 1987, the Court set a deadline for completing discovery and filing any dispositive motions. Pursuant to that schedule, Blue Cross and Wisconsin Bell timely filed the pending motions.

Defendants' motion for summary judgment contends that plaintiff's claims are based on state statutory and tort law, which are pre-empted under the Employee Retirement Income Security Act of 1974, (ERISA) 29 U.S.C. § 1001 et seq.

B. Undisputed Facts

The Court finds that from a review [*3] of the entire record now before the Court, the following facts are undisputed.

Amy Rust, a resident of Milwaukee, is the former spouse of Richard Rust, who was an employee of Wisconsin Bell in 1985. Wisconsin Bell and Blue Cross are both Wisconsin corporations. While the Rusts were married, and while Mr. Rust worked at Wisconsin Bell, Amy Rust was covered as a dependent spouse under a group "Medical Expense Plan" sponsored by Wisconsin Bell and administered by Blue Cross. Plaintiff does not dispute that this plan qualifies as an "employee welfare benefit plan" within the meaning of ERISA.

In November of 1984, Amy Rust became divorced from her husband. Based upon statements made by her husband, Amy Rust believed that her insurance coverage through Wisconsin Bell would end immediately upon her divorce. She did not verify this information with either Wisconsin Bell or Blue Cross.

Amy Rust subsequently obtained health insurance coverage with Mid-America Mutual Insurance Company. In December of 1985, she fell and sustained injuries that required hospitalization. She filed claims with Mid-America,

but Mid-America rejected her claims. She did not submit any claims to Blue Cross for treatment [*4] she received as a result of her injuries.

C. Disputed Facts

Amy Rust, in her complaint and in an affidavit, states that sometime during 1986, she sent a letter to Blue Cross and Wisconsin Bell which read as follows.

To whom it may concern

I am the former wife of Richard Rust, an employee of Wisconsin Bell. Since our divorce, my coverage under Blue Cross/Blue Shield ceased as of 12-1-85. I never did get any type of notice that I could retain said insurance or to convert said insurance so that I would still be provided with coverage after 12-1-85. I have since incurred medical bills because of a fall on ice on Dec. 2, 1985, and I have no insurance coverage.

Please advise immediately as to what I should do in order to retain Blue Cross coverage that was in effect.

Thank You–

Amy Rust
6817 N. 45th St.
Milw. Wisc. 53223

She further states in her affidavit that on May 8, 1986, she received a telephone call from a representative of Blue Cross and was informed by that representative that it was not

Blue Cross' policy to notify ex-spouses of their conversion privileges. She also was informed that she could not covert her insurance coverage and, instead, was advised that she take [*5] out private health insurance.

Blue Cross denies that it ever took any action to terminate plaintiff's coverage and instead states that according to its records, Amy Rust is still an eligible participant of the Wisconsin Bell Plan. Blue Cross also denies that it ever received a copy of the letter plaintiff claimed to send. Blue Cross further states that it keeps records of all telephone contacts with policyholders, but that it has no record of any contact with plaintiff regarding conversion coverage.

II. ANALYSIS

Defendants' motion for summary judgment argues that plaintiff's case is an ERISA-based action arising from an employee welfare benefit plan. As an ERISA-based action, plaintiff must proceed under 29 U.S.C. § 1132 (a) (1) (B), which provides that a participant or beneficiary of an employee welfare benefit plan may bring a civil action to recover benefits due under the plan, to enforce rights under the terms of the plan, or to clarify his rights to future benefits under the plan. Furthermore, plaintiff's claims arising under state law–bad faith, economic duress, emotional distress, conspiracy and punitive damages–are preempted under 29 U.S.C. § 1144, which holds that ERISA [*6] supersedes all state laws insofar as they relate to any employee benefit plan.

Plaintiff responds that "the only issue of relevancy" in this case "centers around defendant's unreasonable refusal to convert plaintiff's health insurance as required by Sec. 632.897, Wis. Stat." Plaintiff's Brief in Opposition to

Defendant's Motion for Summary Judgment at 3. Section 632.897 (2) (b) provides that an insurer of a group plan must allow three months for a group member's former spouse, who would otherwise have her coverage terminated because of the divorce, to elect to continue group policy coverage or convert to individual coverage. Plaintiff further contends that her claims arising from this and other Wisconsin law are "saved" from pre-emption under 29 U.S.C. § 1144 (b) (2) (A), which provides that ERISA does not preempt state laws which regulate insurance.

The court begins by finding that a resolution of defendants' summary judgment motion does not involve a resolution of the disputed facts listed above. n1 Since plaintiff does not dispute that the Wisconsin Bell group medical expense plan qualifies as an employee welfare plan under ERISA, the sole issue before the Court is whether plaintiff's [*7] state action is pre-empted by federal law. This interpretation of federal and state law is a question of law based on the intent of Congress. *See Pilot Life Insurance Company v. Dedeaux*, 107 S. Ct. 1549 (1987). The Supreme Court's decision in *Pilot Life v. Dedeaux* addressed the same issue now before this Court in determining whether ERISA pre-empted the Mississippi law of bad faith. The court began its analysis by reviewing and summarizing the applicable ERISA provisions.

Congress capped off the massive undertaking of ERISA with three provisions relating to the pre-emptive effect of the federal legislation:

"Except as otherwise provided in subsection (b) of this section [the saving clause], the provisions of this subchapter

and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan..." section 514(a), as set forth in 29 U.S.C. § 1141(a) (pre-emption clause).

"Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." section 514 (b) (2) (A), [*8] as set forth in 29 U.S.C. § 1144 (b) (2) (A) (saving clause).

"Neither an employee benefit plan...nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." Section 514 (b) (2) (B), 29 U.S.C. § 1144 (b) (2) (B) (deemer clause).

To summarize the pure mechanics of the provisions quoted above: If a state law "relate[s] to...employee benefit plan[s]," it is pre-empted. Section 514 (a). The saving clause excepts from the pre-emption clause laws that "regulate[e] insurance." Section 514 (b) (2) (A). The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. Section 514 (b) (2) (B)...

In Metropolitan Life [Insurance v. Massachusetts, 471 U.S. 724 (1985)], we were guided by several considerations in determining whether a state law falls under the saving

clause. First, we took what guidance was available [*9] from a "common-sense" view of the language of the saving clause itself. 471 U.S., at 740...Second, we made use of the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson act, 15 U.S.C. § 1011 et seq., in interpreting the clause. Three criteria have been used to determine whether a practice falls under the "business of insurance" for purposes of the McCarran-Ferguson Act:

[F]irst, whether the practice has the effect of transferring or spreading policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. *Union Labor Life Ins. Co. v. Pireno*, 485 U.S. 119, 129 (1982)...

107 S. Ct. at 1551-1554.

n1 Rule 56 of the Federal Rules of Civil Procedure provides that summary judgment shall be granted if the record shows that "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Black v. Henry Pratt Company*, 778 F. 2d 1278, 1281 (7th Cir. 1985). The party moving for summary judgment has the burden of establishing that there is no genuine issue of material fact. *Egger v. Phillips*, 710 F. 2d 292, 296 (7th Cir.), cert. denied, 464 U.S. 918 (1983). The Court must review the entire record with all reasonable inferences drawn from it taken in a light most favorable to the nonmoving party. *Reardon v. Wroan*, 811 F. 2d 1025, 1027 (7th Cir. 1987). [*10]

Turning to the case at hand, the Court finds that plaintiff's claims arising out of or dependent on a violation of section

632.897 (2) (b), Wis. Stats., are pre-empted by ERISA. First, there can be no dispute that the Wisconsin statute relates to an employee benefit plan as defined by ERISA. Compare 29 U.S.C. § 1002(1) with Wis. Stat. § 632.897 (1) (c) 2, 3. Second, the subsection of section 632.897 at issue in this case, (2) (b), governs the continuation of a "group policy" in the case of a divorce. By definition, however, that regulation of "group policy" cannot be deemed a regulation of an employee welfare benefit plan. 29 U.S.C. § 1144 (b) (2) (B). Thus, even though the statute governs insurers as well as plans, the regulation of the plans cannot escape pre-emption. *See General Split Corporation v. Mitchell*, 523 F. Supp. 427, 430-31 (E.D. Wis. 1981) (Gordon, J.) (finding Wis. Stat. 639.897 pre-empted by ERISA on that basis).

Plaintiff alleged claims for bad faith, economic duress, emotional distress and conspiracy, though she does not make clear in her summary judgment response which of these actions are not dependent on a violation of Wis. Stat. § 632.897 (2) (b). Both sides, [*11] however, did discuss whether the tort of bad faith was pre-empted independent of section 632.897 (a) (b).

In *Anderson v. Continental Insurance Company*, 85 Wis. 2d 675, 689, 271 N.W. 2d 368, 375 (1978), the Wisconsin Supreme Court stated that "*every* contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." (Emphasis added.) Thus, since the Wisconsin tort applies to "every contract," not just insurance contracts, bad faith would not meet the requirements of the savings clause under either a common-sense understanding of the phrase "regulates insurance," *see* 107 S. Ct. at 1554, or under an examination of whether the tort is limited to the

insurance industry. Furthermore, the tort of bad faith cannot be said to have an impact on the spreading of policyholder risk, nor is the tort an integral part of the relationship between insured and an insurer. *See Pilot Life*, at 1554-1555 (bad faith tort applies no differently to insurance contract than any other contract). In sum, the analysis of the Wisconsin bad faith tort is almost identical to that of the Supreme Court on Mississippi's bad faith tort. The conclusions certainly [*12] are: the Court finds the Wisconsin tort of bad faith is pre-empted by ERISA.

Again, the parties do not present any explicit analysis on the remaining claims. In light of the Supreme Court's holding in *Pilot Life*, as well as this Court's similar conclusions above, it is difficult for the Court to imagine that the appropriate analysis would be any different from that used for bad faith. Plaintiff offers no Wisconsin law in support of the proposition that the torts apply solely to the insurance industry, that they would spread policyholder risk or that they are an integral part of the relationship between the insured and the insurer. Therefore, to the extent these torts are not pre-empted by their reliance on a violation of the duty imposed by section 632.897, Wis. Stats., the Court finds they are pre-empted under ERISA by the supreme Court's analysis in Pilot Life.

Defendants have also moved to strike plaintiff's jury demand on the basis that ERISA does not provide a right to a jury trial. The Court, however, is unclear on the purpose of this motion. The analysis above eliminates all of plaintiff's pending claims. Plaintiff has not indicated an intention to proceed on ERISA [*13] grounds nor did she request leave to amend the complaint if the Court were to find the state law claims preempted. Defendant's summary judgment motion,

however, seemed to leave the door open for plaintiff to proceed under ERISA. See Brief in Support of Summary Judgment Motion at 6. ("While plaintiff's Complaint makes no specific reference to ERISA, it is clear that the claim is, in actuality, a claim for benefits from the employee benefit plan maintained by Wisconsin Bell.") Therefore, the Court will hold in abeyance the motion to strike the jury demand, pending a discussion on these points with the parties at a status conference.

III. SUMMARY

Plaintiff's suit against Wisconsin Bell and Blue Cross arises out of an employee welfare plan maintained by Wisconsin Bell and administered by Blue Cross. The suit alleges claims under state law for bad faith, economic duress, emotional distress, and conspiracy and relies on duties imposed on group medical plans by Wis. Stat. § 632.897. The state law-based claims, however, are pre-empted by the pre-emption clause of ERISA, 29 U.S.C. §1441(a). The claims are not excepted from pre-emption by ERISA's saving clause, 29 U.S.C. § 1144 (b) (2) (A). [*14] Accordingly, the Court hereby GRANTS the motion of Blue Cross and Wisconsin Bell for summary judgment on plaintiff's bad faith, economic duress, emotional distress, and conspiracy claims.

Defendant's motion to strike plaintiff's jury demand is hereby HELD IN ABEYANCE.

To discuss further proceedings in this case, the Court will hold a status conference at 9:30 a.m. on Thursday, October 6, 1988, in Room 390, Federal Building, 517 East Wisconsin Avenue, Milwaukee, Wisconsin.

SO ORDERED this 21st day of September, 1988, at Milwaukee, Wisconsin.

3044 GOOD FAITH

Every contract implies good faith and fair dealing between the parties and a duty of cooperation on the part of both parties. The law implies a promise against arbitrary or unreasonable conduct.

Good faith means honesty in fact in the conduct or transaction concerned, that is, an honest intention to abstain from taking unfair advantage of another, through technicalities of law, by failure to provide information or to give notice, or by other activities which render the transaction unfair.

There must be an adherence to those reasonable standards of fair dealing which the parties, taking into account the circumstances in which they are doing business, have a right to expect.

Good faith is required at every point, from negotiation through performance.

COMMENT

Estate of Chayka, 47 Wis 2d 102, 176 NW 2d 561 (1970); Wis Stat § 401.203.

17 Am Jur 2d *Contracts* § 256.

Wis Stat § 401.201 (19).

Black's ~~Law~~ Dictionary; *Docter v Furch*, 91 Wis 464, 65 NW 161 (1895); 54 Marq L Rev 1 (1971).

Res. App. 13

Case No. 88-C-0435

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
April 5, 1991

CAROLYN ROBINSON and DERRICK ROBINSON,

Plaintiffs,

v.

COMPCARE HEALTH SERVICES INSURANCE CORPORATION, BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and BRIGGS AND STRATTON CORP,

Defendants.

ORDER OF PARTIAL DISMISSAL

The motion of the defendants Compcare Health Services and Blue Cross & Blue Shield United of Wisconsin to dismiss the complaint herein having been heard and considered by the court, IT IS HEREBY ORDERED AS FOLLOWS:

1. The plaintiffs' claims for "contract damages," "misrepresentation," "bad faith," "tortious interference with contract," "gross conduct outside the scope of ERISA," and "intentional infliction of emotional distress" are DISMISSED on the ground that they do not state a claim upon which relief may be granted under the federal law governing this action,

that being the Employee Retirement Income Security act of 1974, (ERISA) 29 U.S.C. §1001 et seq.

2. The plaintiffs' claim for "breach of fiduciary duty" is DISMISSED as it is alleged in a purely private capacity and any cause of action under ERISA for breach of fiduciary duty inures solely to the benefit of the plan. Therefore, the plaintiff's claim for breach of fiduciary duty, as alleged, does not state a claim on which relief may be granted.

3. The plaintiffs' claim for violation of civil rights under color of state law is DISMISSED on the ground that no state action is alleged, state action being a necessary element of a §1983 claim. Therefore, this alleged cause of action fails to state a claim upon which relief may be granted.

4. The plaintiffs' complaint shall survive dismissal in its entirety on the ground that the complaint appears to arise out of a denial of benefits allegedly due under the terms of an ERISA plan, thus stating a claim under 29 U.S.C. §1132 (a) (1) (B).

BY THE COURT:
/s/ J.P. Stadtmueller
J.P. STADTMUELLER
District Court Judge

LB9L.DMW

Res. App. 15

Civil Action No. 87-C-903 (JPS)

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
January 29, 1991

ANN KOLLER and HENRY KOLLER, JR.,

Plaintiffs,,

v.

AETNA LIFE INSURANCE CO.,
BLUE CROSS AND BLUE SHIELD
UNITED OF WISCONSIN
and BRIGGS & STRATTON CORP.,

Defendants

DECISION AND ORDER

APPEARANCES:

For Plaintiff:

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For Defendants:

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Ann and Henry Koller commenced this action in Milwaukee County Circuit Court after the defendants, Aetna Life Insurance Company ("Aetna"), Briggs & Stratton Corporation ("Briggs & Stratton"), and Blue Cross & Blue Shield United of Wisconsin ("Blue Cross"), refused to cover portions of Ms. Koller's cancer treatment. The case was removed to this court because it raises questions governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. In their multi-count complaint, the Kollers set forth claims for breach of contract, misrepresentation, bad faith denial of insurance benefits, tortious interference with contract, gross conduct outside of the scope or ERISA, breach of fiduciary duty, and intentional infliction of emotional distress. They seek compensatory and punitive damages.

Presently before the court are Aetna and Briggs & Stratton's joint motions for summary judgment and to strike the Kollers' demand for a jury trial, and Blue Cross' motion for summary judgment.

I. Background

The pertinent facts are taken from the complaint and from affidavits submitted by the parties.

A. The Plans

Ann Koller is a Briggs & Stratton employee and a participant in the Briggs & Stratton Benefit Plan for Hourly Employees ("B&S Plan"). The B&S Plan is a self-insured benefit plan funded entirely by Briggs & Stratton. Claims for benefits are processed by Aetna, which decides whether the submitted charges are covered. The plan covers only services or supplies that are "medically necessary," which means that the service or supply must be broadly accepted professionally as essential to the treatment of the disease or injury. Aetna is not at risk for any health care costs.

Ms. Koller is also covered as a dependent under a health plan sponsored by her husband's employer, Western Industries, Inc. The Western Industries' plan ("WI Plan"), like the B&S Plan, is self-insured. Blue Cross processes and pays claims for benefits, then is reimbursed by Western Industries. The WI Plan has a coordination of benefits (COB) provision, which affects benefit payments. Under this provision, a plan that covers an individual "other than as a dependent" is deemed to pay its benefits before a plan that covers the individual as a "dependent." In this case, the mechanics of the COB provision operate to reduce the benefits payable to Ms. Koller under the WI Plan by the amount payable under the B&S Plan. The WI Plan also authorizes Blue Cross to obtain, without the consent of any party, any information needed to implement the COB provision.

B. The Claims and Denials

In 1986, Ms. Koller discovered a lump in her left breast. A biopsy revealed that the lump was cancerous. A modified mastectomy was performed on July 14, 1986. Following the

surgery, Ms. Koller's physician, Dr. Burton Waisbren, Sr., prescribed several months of immunotherapy and chemotherapy.

Aetna covered Ms. Koller's surgery, but referred her claims for the immunotherapy and chemotherapy to its medical consultant, Dr. Henry M. Williams, a board certified oncologist. Based on Dr. Williams' advice, Aetna concluded that the immunotherapy and chemotherapy were not medically necessary and therefore not covered under the B&S Plan. Aetna notified Ms. Koller of its decision in a letter dated March 2, 1987. Aetna also pointed out that its decision was preliminary and that a final decision would not be made until after it received certain medical records from Dr. Waisbren. Aetna further agreed to review any other information that Dr. Waisbren considered pertinent.

After obtaining the additional records, Aetna re-evaluated Ms. Koller's claims. In a letter dated April 16, 1987, Aetna informed her that its initial determination was unchanged and that coverage would not be provided.

Dr. Williams later summarized the bases for his opinion in a June 3, 1987 letter to Dr. William C. Curtis, the medical director at Briggs & Stratton. Dr. Williams stated that immunotherapy had not been shown to be an effective treatment for breast cancer and therefore was not considered usual and customary or medically necessary. He also stated that patients with Stage I breast cancer, like Ms. Koller, were not considered candidates for chemotherapy by practicing oncologists. This led him to conclude that the therapy was investigational rather than medically necessary. To assure that his, as well as Aetna's, conclusions were fair and consistent

with accepted clinical practice, Dr. Williams recommended that a board certified oncologist perform an independent medical examination on Ms. Koller.

Consistent with that recommendation, Ms. Koller was examined by Dr. Edward V. Filmanowicz, a prominent Milwaukee area oncologist, on July 2, 1987. Dr. Filmanowicz consulted with Dr. Ernest Borden of the University of Wisconsin at Madison and Dr. Thomas Anderson of the Medical College of Wisconsin, both professors of oncology at their respective institutions. Dr. Filmanowicz reported their findings in a July 27, 1987 letter to Aetna. All three physicians agreed that immunotherapy for breast cancer patients remains a matter of research and does not constitute a standard of care. They further agreed that while "adjuvant chemotherapy" (the type of chemotherapy given to Ms. Koller) is generally not done in stage I breast patients, it would be difficult to be extremely critical in this case.

Finding herself unable to collect from Aetna, Ms. Koller submitted her immunotherapy and chemotherapy bills to Blue Cross. Blue Cross denied the claims, in accordance with he coordination of benefit (COB) provisions of the WI Plan, for failure to first submit them the the primary carrier.

II. Discussion

The defendants contended that the B&S and WI Plans are employee benefit plans within the meaning of 29 U.S.C. 1002(3) and therefore governed by ERISA. As such, they argue that the Kollers' state law claims are preempted under 29 U.S.C. § 1144. They also contend that in reviewing the denial of ERISA benefits, the court is bound by the decision of the plan administrator unless that decision was arbitrary or

capricious.

The Kollers do not dispute the applicability of ERISA. Instead, they insist that ERISA does not preempt state laws regulating insurance. They further argue that the arbitrary and capricious standard of review is inappropriate and that the court should conduct a *de novo* review.

A. Summary Judgment Standard

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Howland v. Kilquist*, 833 F. 2d 639, 642 (7th Cir. 1987); Fed. R. Civ. P. 56(c). In considering such a motion, the court must view the facts in the light most favorable to the nonmoving party, giving that party the benefit of every reasonable inference that can be drawn from those facts. *Smart v. State Farm Insurance Co.*, 868 F. 2d 929, 931 (7th Cir. 1989). Although the moving party has the burden of showing there are no material facts in dispute, this does not mean that the nonmoving party can simply rest on the pleadings. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 256 (1986). Quite the contrary, to defeat a properly supported motion the nonmoving party must produce sufficient evidence for a jury to return a verdict in his favor. *Anderson*, 477 U.S. at 249.

B. Does ERISA Preempt the Kollers' State Law Claims?

Since the Kollers do not dispute that the B&S and WI plans qualify as employee welfare benefit plans, the first issue the court must address is whether the couple's state law claims–breach of contract, misrepresentation, bad faith, tortious interference with contract, breach of fiduciary duty,

and intentional infliction of emotional distress–and their demand for punitive damages are preempted by ERISA.

The language, structure, and legislative history of ERISA proves convincingly that Congress intended the regulation of employee benefit plans to be an exclusively federal concern.

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...

29 U.S.C. § 1144 (a). The Kollers correctly point out that state laws regulating insurance are not preempted because of ERISA's "savings clause," 29 U.S.C. § 1144 (b) (2) (A). Their analysis, however, ignores the so-called "deemer clause:"

> Neither an employee benefit plan...nor any trust established under such a plan shall be deemed to be an insurance company or other insurer...or to be engaged in the business of insurance...for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts...

29 U.S.C. § 1144 (b) (2) (B). The "deemer clause" prevents an employee benefit plan from being regarded as an insurance company, insurer, or in the business of insurance simply because the plan is self-insured. Consequently, though insured plans (those that purchase insurance) are subject to state laws that "regulate insurance," self-insured plans are not. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). *See also Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F. 2d 416, 425 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988).

The Kollers appear to concede that the WI plan is self-insured. *See* Plaintiffs' Brief in Opposition to Defendant Blue Cross and Blue Shield United of Wisconsin's Motion for Summary Judgment at 14, 15 [hereinafter Plaintiffs' Brief Opposing Blue Cross]. With respect to their claims against Aetna and Briggs & Stratton, they lamely attempt to avoid the holding in *Metropolitan Life* by asserting "[i]t is unclear whether or not Aetna is partially, entirely, or not funded at all by Briggs & Stratton." Plaintiffs' Brief on Opposition to Defendants Aetna Life Insurance Company and Briggs & Stratton Corporation's Motions for Summary Judgment and to Strike Jury Demand at 10 [hereinafter Plaintiffs' Brief Opposing Aetna]. The record, however, clearly indicates that the B&S plan is self-insured; funded entirely by Briggs & Stratton. Wurzer affidavit, ¶ 3.

Moreover, the insured/self-insured distinction would be relevant only if the Kollers' claims were based on state laws that regulate insurance. To regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry. *Pilot Life ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Claims for breach of contract, misrepresentation, tortious interference with contract, breach of fiduciary duty, and intentional infliction of emotional distress stem from general principles of tort and contract law applicable to all industries, not just the insurance industry. Similarly, one branch of this court has found that the Wisconsin tort of bad faith applies no differently to insurance contracts than to any other contract. *Rust v. Blue Cross & Blue Shield United of Wisconsin*, 1988 U.S. Dist. LEXIS 17207 (E.D. Wis. 1988).

In sum, the court finds that the Kollers' state law claims

and demand for punitive damages are preempted by ERISA. Accordingly, the defendants' motions for summary judgment on these claims will be granted and the claims will be dismissed.

C. ERISA Claims

The fifth claim in the Kollers' complaint alleges "gross conduct outside the scope of ERISA." Complaint ¶ 28. The court is uncertain just what this means, but since the couple has indicated a desire to proceed on ERISA grounds in the event their state law claims are preempted, Plaintiffs' Brief Opposing Aetna at 10; Plaintiffs' Brief Opposing Blue Cross at 9, the court will construe the claim as one for relief under 29 U.S.C. § 1132(a).

ERISA permits a participant or beneficiary of an employee benefit plan to bring a civil action to recover benefits allegedly due under the plan. 29 U.S.C. § 1132 (a) (1) (B). The statute, however, does not specify the standard of review to be used in evaluating claims for wrongful denial of benefits. After this suit was filed the Supreme Court handed down its decision in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), which altered the standard of review of a plan administrator's decision to deny ERISA benefits.

Before *Bruch*, courts generally deferred to the judgment of plan administrators, reversing their decisions only if they were "arbitrary and capricious." *See, e.g., Pokratz v. Jones Dairy Farm*, 771 F. 2d 206, 208 (7th Cir. 1985) and cases cited therein. In *Bruch*, the Court, guided by principles of trust law, held that "a denial of benefits challenged under 1132 (a) (1) (B) is to be reviewed under a *de novo* standard

unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. The purpose of *de novo* review is to provide greater assurance that employees will get the plan benefits to which they are entitled. Under the *de novo* standard, the court independently construes the term of the plan to determine whether the administrator's decision was proper.

Shortly after *Bruch* was decided, the defendants submitted supplemental correspondence explaining why their decisions should be reviewed under the arbitrary and capricious standard. Aetna and Briggs & Stratton, evidently conceding that the B&S Plan does not grant discretionary authority to them, contend that *Bruch* should not be applied retroactively. Blue Cross, on the other hand, argues that there is a grant to discretion in the WI Plan. These arguments will be addressed separately.

1. Retroactive Application of *Bruch*

For a decision to be applied only prospectively, it must satisfy the three-prong test put forth in *Chevron Oil Co. v. Huson*, 404 U.S. 97 (1971). The decision must (1) establish a new principle of law, either by overruling clear past precedent or by deciding an issue of first impression; (2) state a rule that would be retarded rather than furthered by retroactive application, given the rule's history, purpose, and effect; and (3) if applied retroactively, produce substantial inequitable results–results that would be avoided by prospective application only.

Id. at 106-07.

Applying this test, the court concludes *Bruch* should be applied retroactively. While *Bruch*, by substantially changing the standard of review in benefit cases, easily satisfies the first prong of the Chevron test, it does not satisfy the second and third prongs. Before enactment of ERISA, actions challenging an employer's denial of benefits were governed by principles of contract law. *Bruch*, 489 U.S. at 112. The court reviewed an employee's claim as it would any other contract claim–by looking at the terms of the plan and other manifestations of the parties' intent. *Id.* at 112-13. ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans and to protect contractually defined benefits. *Id.* at 113. Yet under the arbitrary and capricious standard, employees and beneficiaries actually enjoyed less protection than they did before ERISA was enacted. *De novo* review remedies this problem as such, applying it retroactively would further rather than retard the goals of ERISA.

Furthermore, retroactive application of *Bruch* in this case would not produce substantial inequities. Although Aetna and Briggs & Stratton may have relied on the arbitrary and capricious standard in structuring the B&S Plan, *de novo* review does not increase their liability under the plan, it simply increases the probability that the court will disagree with their interpretation of the plan. The court rejects the notion that Aetna, Briggs & Stratton, and Blue Cross will suffer substantial hardship simply because they were counting on greater deference for an interpretation that may not be supported by the terms of the plan.

2. Application of the Bruch Standard to Aetna and Briggs & Stratton

Both sides have submitted affidavits on the issue of whether immunotherapy and chemotherapy were medically necessary for the treatment of Ms. Koller. Aetna and Briggs & Stratton rely on the previously discussed findings of Drs. Williams and Filmanowicz to support their position. Wurzer affidavit, Exhibits D, G. The Kollers counter with an affidavit from Dr. Waisbren who asserts that the treatments were not only medically necessary, but also were accepted by a large segment of the medical community. Waisbren affidavit, ¶¶ 2, 3. Ironically, this assertion is buttressed somewhat by Dr. Filmanowicz's concession that it is difficult to be extremely critical of the use of adjuvant chemotherapy in this instance. Wurzer affidavit, Exhibit G.

At this juncture, the court cannot say whether Aetna and Briggs & Stratton's decision to deny benefits was proper. Obviously, a material factual dispute remains as to the medical necessity of immunotherapy and chemotherapy. Accordingly, Aetna and Briggs & Stratton's joint motion for summary judgment on the ERISA claim will be denied.

3. Discretionary Authority of Blue Cross

Blue Cross purportedly derives its discretionary authority from two sources: (1) Section C of the Coordination of Benefits provision, which authorizes Blue Cross to release or obtain any information necessary to properly administer the COB provision without the consent of any party; and, (2) the General Exclusions (GE) provision, which authorizes Blue Cross to determine whether a treatment, service or supply is generally accepted medical practice and eligible for payment.

The Seventh Circuit has stated that no "magic words" (such as "the committee has discretion to...") are required to

vest the administrator with sufficient discretion to avoid *de novo* review. *Bali v. Blue Cross & Blue Shield Ass'n.*, 873 F. 2d 1043, 1047, (7th Cir. 1989). Furthermore, at least one court has read *Bruch* to exempt from *de novo* review not just decisions of administrators whose plans granted them discretionary authority, but also denials of benefits not based on plan interpretations. *Petrilli v. Drechsel*, 1989, U.S. Dist. LEXIS 10763 (N.D. Ill. 1989), *rev'd on other grounds*, 910 F. 2d 1441, 1447 (7th Cir. 1990). Resolution of the appropriate standard of review in this instance, however, must wait until another day since a material fact is in dispute.

As noted earlier, under the WI Plan's COB provision the B&S Plan is deemed to pay its benefits first since the WI Plan covers Ms. Koller only as a dependent. According to Blue Cross, the only way it could verify that Ms. Koller had submitted her claims to Aetna (her primary carrier) before sending them to Blue Cross was by obtaining documentation indicating Aetna had processed the claim. The most common form of documentation is an explanation of benefits (EOB). Kathleen Jury, Dr. Waisbren's office manager, insists that she not only billed Aetna first but also sent a copy of Aetna's EOB to Blue Cross when it was billed. Jury affidavit, ¶ 4. Blue Cross admits receiving some EOB's from Dr. Waisbren's office, but not for the claims in question. It goes on to call the inference from Ms. Jury's statement–that it denied 25 claims, over six months, from the same subscriber, for the same wrong reason–preposterous.

Suffice to say, the outcome of this question will have to be determined at trial. Accordingly Blue Cross' motion for summary judgment on the ERISA claim will be denied.

D. Punitive Damages under ERISA

In their complaint, the Kollers seek punitive damages and in their briefs they argue that they are entitled to such damages under 29 U.S.C. § 1132 (a) (3), despite the overwhelming precedent to the contrary. *See, e.g., Amos v. Blue Cross-Blue Shield*, 868 F. 2d 430, 431 (11th Cir.), cert. denied, 493 U.S. _____, 110 S. Ct. 158 (1989); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F. 2d 821, 825 (1st Cir.), *cert. denied*, 488 U.S. 909 (1988); *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F. 2d 1302, 1307 (9th Cir. 1986); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F. 2d 1456, 1463 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987); Powell v. Chesapeake and Potomac Tel. Co., 780 F. 2d 419, 424 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). Their analysis of the pertinent case law conveniently overlooks *Kleinhans v. Lisle Sav. Profit Sharing Trust*, 810 F. 2d 618 (7th Cir. 1987) in which the Seventh Circuit explicitly stated that punitive damages are not recoverable under § 1132 (a) (3) of ERISA. *Id.* at 627. Furthermore, as the Supreme Court pointed out in *Bruch*, ERISA should be interpreted consistent with the principles of trust law. 489 U.S. at 110-15. In the trust context, punitive damages are generally awarded only when malice or fraud is involved, G. BOGERT & G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 862 (rev. 2d ed. 1982), neither of which was pleaded here.

E. Right to a Jury Trial

Finally, the defendants have moved to strike the Kollers' demand for a jury trial. Citing *Wardle v. Central States, Southeast & Southwest Areas Pension Fund*, 627 F. 2d 820

(7th Cir. 1980), *cert. denied*, 449 U.S. 1112 (1981), the defendants argue that since ERISA claims are of an equitable nature, no right to a jury trial exists. The Second, Third, Fourth, Sixth, Eight and Eleventh Circuits have reached the same conclusion. *See, e.g. Blake v. Unionmutual Stock Life Ins. Co.*, 906 F. 2d 1525, 1526 (11th Cir. 1990); *Cox v. Keystone Carbon Co.* 894 F. 2d 647 (3rd Cir.), *cert. denied*, 498 U.S. _____, 111 S. Ct. 47 (1990); *Daniel v. Eaton Corp.*, 839 F. 2d 263, 268 (6th Cir.), *cert. denied*, 488 U.S. 826 (1988); *Berry v. Ciba-Geigy Corp.*, 761 F. 2d 1003, 1006-07 (4th Cir. 1985); *Katsaros v. Cody*, 744 F. 2d 270 (2d Cir.), *cert. denied*, 469 U.S. 1072 (1984); *In re Vorpahl*, 695 F. 2d 318 (8th Cir. 1982).

In light of the prevailing case law, the court is compelled to conclude that the Kollers do not have a right to a jury trial under ERISA. Nor does the court believe that the heightened review mandated by *Bruch* dictate a different conclusion because the nature of the action is unaffected by the standard of review. *See Blake*, 906 F. 2d at 1526. Although the Kollers are claiming money damages, in effect they are seeking to enforce their benefits under the two plans. Assuming Ms. Koller required additional treatment, the appropriate remedy would be an order to provide benefits–an equitable remedy.

III. Conclusion

To summarize, the Kollers' state law claims for beach of contract, misrepresentation, bad faith, tortious interference with contract, breach of fiduciary duty, and intentional infliction of emotional distress, as well as any state law demand for punitive damages are preempted by ERISA and must be dismissed. Summary judgment of the ERISA claims

is inappropriate because there are material facts still in dispute. The Kollers, however, are not entitled to punitive damages or to a jury trial on their ERISA claim.

Therefore,

IT IS ORDERED that the defendants' motions for summary judgment on the claims of beach of contract, misrepresentation, bad faith, tortious interference with contract, breach of fiduciary duty, and intentional infliction of emotional distress be and the same are hereby **GRANTED**; and,

IT IS FURTHER ORDERED that the defendants' motions for summary judgment on the ERISA claims be and the same are hereby **DENIED**; and,

IT IS FURTHER ORDERED that the plaintiffs' demand for punitive damages be and the same is hereby **DENIED**; and

IT IS FURTHER ORDERED that the defendants' motion to strike the plaintiffs' demand for a jury trial on the ERISA claims be and the same is hereby **GRANTED**.

Dated at Milwaukee, Wisconsin this 29th Day of January, 1991.

BY THE COURT;
/s/J.P. Statmueller
J.P. Statmueller
U.S. District Judge

Res. App. 31

Civil Action No. 87-C-1224

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
October 7, 1988

EMMA McGREW and BENNIE McGREW,

Plaintiffs,

v.

WISCONSIN PHYSICIANS SERVICE INSURANCE CORP., BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and MILWAUKEE COUNTY,

Defendants.

ORDER

Currently pending are motions of the defendants for dismissal of the action or for summary judgment.

The undisputed facts show that Emma McGrew is an employee of Milwaukee County. Since January 1, 1985, the county has furnished a health benefits plan to its employees, retirees, and their dependents. The plan is self-funded and is administered by Wisconsin Physicians Service. As a county employee, Mrs. McGrew has WPS as her primary insurance carrier.

Bennie McGrew is a retiree of the Ladish Company. He also had family health coverage under which Mrs. McGrew

was covered as a dependent spouse. His plan is a self-insured plan sponsored by the Ladish Company and administered by Blue Cross & Blue Shield United of Wisconsin.

The Ladish plan contains a "Coordination of Benefits" clause, which requires that claims first be presented to the insured's primary carrier. If that carrier rejects a claim, it can then be presented to Blue Cross.

Emma McGrew has a condition diagnosed as chronic lymphatic leukemia and osteomyelitis. She has been a patient of Dr. Burton Waisbren, Sr. of the Waisbren Clinic since April 1985. During that time she has received immunotherapy treatments on a monthly basis.

Some of her bills submitted to WPS for the immunotherapy treatments were paid initially. However, WPS has subsequently refused payment of a portion of 11 claims, involving 33 rejected services, for a total of $2,387. The claims, if they had been paid, would have been reimbursed at 80%, subject to an annual deductible of $50, for a total of $1,909.

Emma McGrew has also submitted two claims to Blue Cross. The first was for service on April 25, 1985; the total claim was $49. Blue Cross paid the claim, minus a $9.80 co-payment portion. The second was a claim for reimbursement of a number of prescription drug charges totaling $458.80. The claim was rejected because it had not first been filed with the primary carrier, WPS.

The McGrews filed a complaint in the circuit court for Milwaukee County, with claims against the defendants for breach of contract, misrepresentation, bad faith, tortious

interference with contract, "gross conduct" outside the scope of ERISA, breach of a fiduciary duty, and emotional distress. They seek contract damages in the amount of $50,000; other compensatory damages in the amount of $2,000,000; and punitive damages in the amount of $10,000,000, plus costs and disbursements. The action was removed to this court and the defendants have filed motions for dismissal of the action or for summary judgment.

Blue Cross has moved for summary judgment and for an order striking plaintiffs' jury demand. Blue Cross claims that plaintiffs' state law claims against it are preempted under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (ERISA). In addition, Blue Cross requests sanctions against plaintiffs, pursuant to rule 11 of the federal Rules of Civil Procedure, for the frivolous and excessive nature of the punitive damage claim.

WPS, joined by Milwaukee County, contends that it is entitled to summary judgment because (1) neither it nor the county received notice of the claims as required by § 893.80, Wisconsin Statutes; (2) as a matter of law, plaintiffs cannot maintain an ERISA action against WPS; (3) the compensatory damage request is excessive; and (4) the punitive damage request is frivolous.

First, to discuss the ERISA issues: Blue Cross claims that plaintiffs' state law claims are preempted by ERISA; WPS, joined by Milwaukee County, claims that no ERISA claim can be maintained against it. The defendants are correct.

ERISA provides that a participant in a plan may bring an action

> to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

The preemptive effect of ERISA is governed by 29 U.S.C. § 1144. Section 1144 (a) states that ERISA supersedes any state laws which relate to employee benefit plans described in section 1003(a). Section 1003(a) states that the law applies to benefit plans maintained by an employer or by an organization of employees. Also pertinent here, however, is section 1003(b) which states that the provisions do not apply to government plans. Thus the difference in the positions of WPS and Blue Cross. WPS administers a government plan; Blue Cross a private plan.

Other statutes also must be considered. Section 1144(b) (2) (A), known as the "savings" clause, states that nothing in the act "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." And section 1144 (b) (2) (B), known as the "deemer" clause, states that no plan described in section 1003 (a), which is where this saga began, shall be "deemed to be an insurance company..."

The effect of the savings clause and the deemer clause is that if a plan is self-insured, even if it is administered by an insurance company, ERISA preempts state law. The plan then is deemed not to fall under provisions applying to insurance companies and the savings clause does not apply. *See Moore v. Provident Life and Accident Insurance Company*, 786 F. 2d 922 (9th Cir. 1986); *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F. 2d. 416 (7th Cir. 1988). The result of the statutory scheme is that the claims against Blue Cross are preempted by ERISA, but no ERISA claim can be

brought against WPS or Milwaukee County.

Even if the state law claims against Blue Cross are preempted, there could be an argument that extracontractual damages are available under the language in 29 U.S.C. § 1132(a) (3) calling for "other appropriate equitable relief." However, as have the majority of the other circuits, the Court of Appeals for the Seventh Circuit has concluded that extracontractual damages are not available. *Pokratz v. Jones Dairy Farm*, 771 F. 2d 206 (7th Cir. 1985).

Plaintiffs' claim against Blue Cross, then, is a claim for benefits under ERISA. As stated above, two claims were submitted to Blue Cross. One was paid, except for the co-payment. The other, for $458.80, was rejected on the basis of the Coordination of Benefits clause. Blue Cross contends that it sent the McGrews an "Explanation of Benefits" form advising them to submit the claim to the primary carrier. Although it is not entirely clear, the McGrews may be contending that they never received the form. They do not, however, contest the existence of a valid coordination of benefits clause. At this time they also clearly have notice that Blue Cross has rejected the claim and the basis for that rejection. The lawsuit is not ripe. They should submit the claim to WPS and see what happens. If it is rejected by WPS, they can submit it to Blue Cross. If Blue Cross rejects it, perhaps an ERISA claim can be maintained. The ERISA claim against Blue Cross will be dismissed. Given this posture of the case, the punitive damage claim against Blue cross must also fall.

WPS argues that the claims against it (and Milwaukee County) must fail because plaintiffs did not file a notice of

claim as required by §893.80, Wisconsin Statutes.

A plaintiff need not allege in his complaint that he has complied with section 893.80, but the requirement of the statute must be satisfied before a suit can be brought against a government body or its agent. *Weiss v. City of Milwaukee,* 79 Wis. 2d 213 (1977). If a defendant raises the issue, a plaintiff has the burden of proving compliance with the statutory conditions. *Elkhorn Area School District v. East Troy Community School District*, 110 Wis. 2d 1 (Ct. App. 1982).

If a plaintiff has not filed a notice, then he may not proceed with the lawsuit unless he can prove that WPS or the county had actual notice of the claims and that the failure to give notice was not prejudicial.

The McGrews state that no notice is required against the county because no claim is made against the county except to the extent that contract benefits are due. They further contend that WPS is not entitled to notice. The argument is that the notice requirement applies only to the county and its agents. There is no evidence, they argue, of an agency relationship between WPS and the county; rather WPS is an independent contractor. The McGrews also claim that, in any case, the issue as to whether an agency relationship exists is a jury question.

The McGrews cite *Scheuer v. Central States Pension Fund,* 358 F. Supp. 1332 (E.D. Wis. 1973) for the proposition that it is a jury question as to whether an agency exists. In *Scheuer* it was a jury question; however, that is not always the case. In *Lofy v. Joint School district No. 2*, 42 Wis. 2d 253 (1969), the court upheld a decision granting summary judgment on the issue. The court analyzed the contract and

found that the entity in question was an independent contractor, not an agent.

Ordinarily, where a written contract exists, construction of the contract is a question of law for the court. *Koenings v. Joseph Schlitz Brewing Co.*, 126 Wis. 2d 349 (1985); *Streiff v. American Family Mutual Insurance Co.*, 118 Wis. 2d 602 (1984). Here a contract exists under which WPS administers the group plan. Section III(i) of the contract provides:

> WPS, in performing its obligations under this Agreement, is acting only as agent of the Group and shall not be designated or deemed the fiduciary with respect to the Plan under any federal or state law.

That provision alone would perhaps not be dispositive of the issue. However, other provisions of the contract support the contention that WPS is an agent.

In determining whether an agency relationship exists, the "most important single indicium is who has retained the right to control the details of the work." *Lofy, supra*, at 262, quoting *Madix v. Hochgreve Brewing Co.*, 154 Wis. 448 (1913). In this case, while WPS makes the initial determination as to the extent of benefits to be paid to any claimant, the county Group retains the right to have the final word. *See* section III (b). Further, the Group assumes all responsiblitity for state or federal laws which apply to the agreement. *See* section III (h). I find that WPS is an agent and is entitled to a notice of claim, under section 893.80.

As stated above, however, if WPS or the county had actual notice of the claims asserted in the complaint and if the failure to give statutory notice was not prejudicial, the action

can proceed. It seems clear here that WPS had actual notice of the contractual claim for payment of benefits. However, the McGrews make no attempt to show that WPS knew that it would be sued for $2,000,000 in compensatory damages, $50,000 in contract damages, and $10,000,000 in punitive damages. The contract claim for payment of benefits may proceed. The other claims are dismissed.

Even were there no agency relationship found here, WPS (as did Blue Cross) argues that the damages requested are far out of line with the benefits allegedly due. WPS states that in any case, the tort liability of a governmental body cannot exceed $50,000. § 893.80(3), Wisconsin Statutes. In regard to the request for punitive damages, both parties seek sanctions pursuant to rule 11 of the Federal Rules of Civil Procedure on the basis that the claim is frivolous.

The appropriate sanction, both contend, is dismissal of the punitive damage claim. As stated above, the claim is dismissed on other grounds; however, even if it had not been, I would dismiss it with prejudice as an appropriate sanction under rule 11.

Thus, I will, in an exercise of discretion, remand the remainder of the dispute to the state court, where it was originally filed. *See Carnegie-Mellon University v. Cohill*, 108 S. Ct. 614 (1988).

IT IS THEREFORE ORDERED that all claims in this lawsuit with the exception of a contract claim for benefits against WPS and Milwaukee County are DISMISSED.

IT IS FURTHER ORDERED that this action is remanded to the Circuit Court for Milwaukee County.

Dated at Milwaukee, Wisconsin this 7th day of October, 1988.

BY THE COURT:
/S/ Terence Evans
TERENCE T. EVANS
UNITED STATES DISTRICT JUDGE

JUDGMENT IN A CIVIL CASE

United States District Court	DISTRICT Eastern District of WI
CASE TITLE	
McGREW, EMMA, et al. V. WISCONSIN PHYSICIANS SERVICE CORP., et al.	DOCKET NUMBER 87-C-1224 NAME OF JUDGE Terence T. Evans

Decision by Court. This action came to trial or hearing before the Court with the judge named above presiding. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

That all claims in this lawsuit with the exception of a contract claim for benefits against WPS and Milwaukee County are DISMISSED.

It is further ordered that this action is remanded to the Circuit Court for Milwaukee County.

CLERK Sofron B. Nedilsky	DATE
(BY) DEPUTY CLERK /s/ Regina Torcivia	10/7/88

Civil Action No. 89-3523, no. 90-1378

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
1992 U.S. App. LEXIS 5497
February 14, 1991, Argued
March 27, 1992, Decided

JACKSON B. SMITH and VIVIAN E. SMITH,
Plaintiffs-Appellants,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and DELCO ELECTRONICS CORPORATION,
Defendants-Appellees

JACKSON B. SMITH and VIVIAN E. SMITH,
Plaintiffs-Appellants,
and MARJAN R. KMIEC,
one of the Attorneys for Plaintiffs, Appellant,

v.

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and DELCO ELECTRONICS CORPORATION,
Defendants-Appellees.

PRIOR HISTORY: [*1] Appeal from the United States District Court for the Eastern District of Wisconsin. No. 89 C 473–Robert W. Warren, Judge.

DISPOSITION: AFFIRMED.

COUNSEL: For JACKSON B. SMITH, Plaintiff - Appellant: Marjan R. Kmiec, 414/649-9790, Christopher A. McConville, 414/649-9790, 3741 W. National Avenue, Milwaukee, WI 53215, USA. For VIVIAN E. SMITH, Plaintiff - Appellant: Marjan R. Kmiec, 414/649-9790, Christopher A. McConville, 414-649-9790, 3741 W. National Avenue, Milwaukee, WI 53215, USA.

For BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN, Defendant - Appellee: Kim M. Cafaro, 414/226-6925, Laurel Barnes, 414/226-6289, BLUE CROSS & BLUE SHIELD OF WISCONSIN, 401 W. Michigan Street, Milwaukee, WI 53201, USA. For DELCO ELECTRONICS, a General Motors Corporation, Defendant - Appellee: Susan R. Maisa, 414/271-2400, George D. Cunningham, 414/289-3577, FOLEY & LARDNER, 777 E. Wisconsin Avenue, Milwaukee, WI 53202, USA.

For MARJAN R. KMIEC, one of the attorneys for plaintiffs, Appellant: Christopher A. McConville, 414/649-9790, Marjan R. Kmiec, 414/649-9790, 3741 W. National Avenue, Milwaukee, WI 53215, USA.

For JACKSON B. SMITH, Plaintiff - Appellant: Marjan R. Kmiec, 414/649-9790, Christopher A. McConville, 414/649-9790, [*2] 3741 W. National Avenue, Milwaukee, WI 53215, USA. For VIVIAN E. SMITH, Plaintiff - Appellant: Marjan R. Kmiec, 414/649-9790, Christopher A. McConville, 414/649-9790, 3741 W. National Avenue, Milwaukee, WI 53215, USA.

For BLUE CROSS & BLUE SHIELD UNITED OF

WISCONSIN, Defendant - Appellee: Kim M. Cafaro, 414/226-6925, Laurel Barnes, 414/226-6289, BLUE CROSS & BLUE SHIELD OF WISCONSIN, 401 W. Michigan Street, Milwaukee, WI 53201, USA. For DELCO ELECTRONICS, a General Motors Corporation, Defendant - Appellee: Susan R. Maisa, 414/271-2400, George D. Cunningham, 414/289-3577, FOLEY & LARDNER, 777 E. Wisconsin Avenue, Milwaukee, WI 53202, USA.

JUDGES: Before WOOD, JR. n1 and POSNER, Circuit Judges, and FAIRCHILD, Senior Circuit Judge.

n1 Judge Wood, Jr., assumed senior status January 16, 1992, after oral argument of this case.

OPINION BY: FAIRCHILD

OPINION: FAIRCHILD, Senior Circuit Judge. In March 1989, the Smiths filed a complaint against Delco Electronics and Blue Cross and Blue Shield in a Wisconsin court. The complaint alleged that Mr. Smith was employed by Delco Electronics and that he and his wife were beneficiaries of Delco's group insurance plan, which was insured by Blue Cross. It alleged in an [*3] introductory portion that the plan provided remedies both under the Employment Retirement Income Security act of 1974 (ERISA), 29 U.S.C. § 1001 et seq. and state law. Because of Mr. Smith's arthritis and Mrs. Smith's diabetes, they undertook a weight loss program under medical supervision and submitted the bills to Blue Cross for payment. On August 20, 1987, Blue Cross denied the Smiths' claims. Although the complaint asserted plaintiffs' entitlement to ERISA remedies, it set forth as separate claims for relief state law claims that the denial was a breach of contract, was done in bad faith, that the denial was a

breach of fiduciary duty, caused emotional distress, and deprived them of constitutional rights to life, liberty and property.

Delco and Blue Cross removed the case to federal court on the ground that the action arose under the constitution and laws of the United States, including ERISA. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (exception to well-pleaded complaint rule when ERISA preemption is a defense). Delco and Blue Cross then moved to dismiss the case on grounds that the state causes of action were preempted by ERISA and that [*4] the constitutional claims could be based only on actions by government entities. In the alternative, they moved for summary judgment on the ground that if the complaint be construed as an ERISA claim for benefits, it must be dismissed because the Smiths did not exhaust their internal remedies under the plan. Delco and Blue Cross also moved for sanctions pursuant to Rule 11 of the Federal Rules of Civil Procedure. The district court dismissed the action and imposed sanctions against the plaintiffs' attorneys, awarding defendants their costs and reasonable attorneys' fees. *Smith v. Blue Cross & Blue Shield United of Wisconsin*, 724 F. Supp. 618 (E.D. Wis. 1989). Delco and Blue Cross requested fees and costs of $17,244.32, and the district court awarded $12,874.32. The Smiths and Mr. Kmiec, one of their attorneys, have appealed. The issues before us are whether the Smiths' state law claims are preempted by ERISA, whether they exhausted their internal remedies under the plan, and whether the court erred by awarding sanctions.

ERISA PREEMPTION

ERISA preempts all state laws which "relate to any employee benefit plan," 29 U.S.C. § 1144 (a) (preemption clause), unless [*5] the state law "regulates insurance, banking, or securities," 29 U.S.C. § 1144 (b) (2) (A) (saving clause). However, self-funded plans are exempt from state laws that regulate insurance. 29 U.S.C. § 1144 (b) (2) (B) (deemer clause); *FMC Corp. v. Holliday*, 111 S. Ct. 403, 409 (1990). The Supreme Court has held that ERISA preempts state common law tort and contract actions, including bad faith claims, "asserting improper processing of a claim for benefits under an ERISA-regulated plan." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987). In *Pilot Life*, the Court said that the bad faith common law cause of action asserted there relates to an employee benefit plan. The cause of action therefore comes under the preemption clause, and is not saved because the state (Mississippi) law of bad faith does not regulate insurance.

Although the Smiths' state common law tort and contract claims are the same as those brought by the plaintiffs in *Pilot Life*, the Smiths argue that *Pilot Life* does not apply to Wisconsin's bad faith common law. They argue that in *Pilot Life*, the Court considered Mississippi's law of bad faith, and that Mississippi's [*6] law applies generally while Wisconsin's law of bad faith is applied only to insurance contracts. That distinction cannot be maintained. In *Pilot Life*, the Court said,

Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for

punitive damages under Mississippi law.

Id. at 50. Wisconsin's law of bad faith is similarly "planted in the general principles of [Wisconsin] tort and contract law." In *Anderson v. Continental Ins. Co.*, 271 N.W. 2d 368, 371 (Wis. 1978), the Wisconsin Supreme Court recognized "a cause of action in tort against an insurer for the bad faith refusal to honor a claim of the insured." The court analyzed the bad faith action as a typical tort case:

By virtue of the relationship between the parties created by the contract, a special duty arises, the breach of which duty is a tort and is unrelated to contract damages. This tort of bad faith or malicious and intentional harassment [*7] by one party to a contract directed toward the other party,who seeks to assert his contract claim, has been referred to as a "tortious breach of contract."

Id. at 374. The court also relied on standard contract principles: "'Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.'" Id. at 375 (quoting Restatement of Contracts, Second, § 231 (tentative drafts Nos. 1-7, rev. and edited, 1973)). Thus, under *Pilot Life* the Smiths' claims are clearly preempted by ERISA. This court has found preemption of the same and comparable state law causes of action in two cases decided since oral argument of the Smiths' appeal. *Tomczyk v. Blue Cross & Blue Shield*, 951 F. 2d 771, 775 (7th Cir. 1991); *Maciosek v. Blue Cross & Blue Shield*, 930 F. 2d 536, 538-40 (7th Cir. 1991). Attorneys for the plaintiff were the same in all three cases.

The Smiths argue that even if their claims are preempted by ERISA, ERISA applies only to plan fiduciaries, and there

is no evidence that Delco and Blue Cross are both fiduciaries. The Smiths, however, have waived this claim [*8] because they presented it for the first time on appeal. *Maciosek*, 930 F. 2d at 540 n. 2. Moreover, in their complaint, the Smiths alleged, "the defendants have various fiduciary duties to the plaintiffs."

EXHAUSTION

The Smiths next argue that even if state law claims are preempted, their complaint also asserts claims under ERISA. The complaint sets forth as separate claims for relief only state law causes of action, and the claim alleging deprivation of constitutional rights. The complaint, in describing the employee benefit plan, says the plan provides remedies under both state law and under ERISA. The complaint would not ordinarily be treated as sufficient pleading of a claim under ERISA. This court has recently considered whether a complaint filed by the same lawyer representing the Smiths could be construed to include ERISA claims. The court held,

Their decision here to file only state claims in state court, thereby ignoring ERISA, can only be seen as a strategic attempt to avoid removal to federal court. The [plaintiffs] never sought to amend their complaint to add ERISA counts, even after their strategy failed and the case was removed to federal court. [*9] They are bound by those decisions.

Maciosek, 930 F. 2d at 540-41. See, however, *Bartholet v. Reischauer*, slip op. No. 90-2671 (7th Cir., Jan. 15, 1992) holding that a pleading which gives sufficient notice of a claim showing that the pleader is entitled to relief under ERISA should not be dismissed for failure expressly to invoke ERISA.

Even construing the complaint as stating an ERISA claim, we affirm. The district court wrote that summary judgment would then be appropriate because plaintiffs had not exhausted their internal plan remedies. *Smith*, 724 F. Supp. at 622. A district judge may so decide, and we would disturb this decision only if there has been a clear abuse of discretion. *Powell v. A.T. & T. Communications, Inc.*, 938 F. 2d 823, 925 (7th Cir. 1991); *Kross v. Western Electric Co.*, 701 F. 2d 1238, 1244 (7th Cir. 1983). Judgment on this theory will not prevent plaintiffs from exhausting their plan remedy, assuming they are not barred by lapse of time, and then suing upon the merits.

The Smiths argue that requiring exhaustion would be an abuse of discretion because although they did not exhaust [*10] their internal plan remedies, n2 two exceptions to the exhaustion requirement apply to them. First, the Smiths claim the futility exception applies to their claims, although they do not explain why an appeal would be futile. In order to come under the futility exception, the Smiths must show that it is certain that their claim will be denied on appeal, not merely that they doubt an appeal will result in a different decision. *Dale v. Chicago Tribune Co.*, 797 F. 2d 458, 467 (7th Cir. 1986) ("absence of 'neutral arbitrator' does not, by itself, render the exhaustion of such procedures futile"), cert. denied, 479 U.S. 1066 (1987); *Carter v. Signode Industries, Inc.*, 688 F. Supp. 1283, 1287 (N.D. Ill. 1988) (exhaustion was futile where putative class members had appealed decision and the Director of the Plan "made it clear that no adjustments were forthcoming"). Because the Smiths have represented no facts to show that the review procedures would not work, the futility exception does not apply.

– – – – – – – – Footnotes – – – – – – – –

n2 In their complaint, the Smiths allege that they exhausted their internal remedies, but in their brief they seem to concede that they did not, and an affidavit by Delco's supervisor of benefit plan administration states they did not. Although the Smiths could appeal the claims by merely notifying their local union benefit representative that their claims had been wrongly denied, they did not do so. In his affidavit, Mr. Smith said he contacted his union benefit representative four times, but he said these contacts occurred in 1986, and his claims were not denied until August 20, 1987. The appellate procedure clearly requires that the claimant contact the union benefit representative after the denial of the claim.

– – – – – – – – End Footnotes – – – – – – – –

[*11]

The second exception to the exhaustion requirement is that claimants are not required to appeal when there is a lack of meaningful access to the review procedures. *Carter*, 688 F. Supp. at 1287-88 (there is a lack of meaningful access if claimant attempts to initiate higher levels of review procedure, but a party has denied claimant access to higher levels of review); *Boesl v. Suburban Trust & Sav. Bank*, 642 F. Supp. 1503, 1516 (N.D. Ill. 1986) (claimant denied meaningful access because he was not told how to file appeal or told review procedure was available). The Smiths claim they were denied access because, subsequent to the denial of their benefits, they repeatedly requested review, but received no response. There is, however, no support in the record for this assertion. In his affidavit, Mr. Smith says that he asked

his union benefit representative to request review and that his lawyer wrote to Blue Cross to request review. These requests, however, occurred in 1985 and 1986, and the Smiths' claim was not denied until August 20, 1987. At oral argument, the Smiths claimed for the first time that they could not appeal because they had never [*12] been informed of the review procedures, despite having requested a plan booklet several times. Not only is there no evidence in the record that the Smiths were unaware of the review procedures, but the Smiths waived this argument by failure to raise it before the district court.

SANCTIONS

The Smiths' lawyer, Mr. Kmiec, has appealed both the decision to award attorneys' fees under Rule 11 and the amount of the fee award. The district judge explained the basis for his award of sanctions: n3

This action encompasses a classic violation of Rule 11. No reasonable attorney having read *Pilot Life* and *Taylor* could manufacture a good faith argument as to why this suit should be brought. Further, any attorney making a "a reasonable inquiry" would have come across *Pilot Life* and *Taylor*. This case is contrary to settled precedent, and falls directly into the *Eastway Construction [Corp. v. City of New York*, 762 F. 2d 243, 254 (2d Cir. 1985),] definition of having no chance of success under existing precedent. That defense counsel alerted plaintiffs' counsel of the frivolity of the claim and pointed the attorneys to the directly contrary precedent only exacerbates [*13] the unreasonableness of plaintiffs' counsels' actions.

Smith, 724 F. Supp. at 623.

– – – – – – – – Footnotes – – – – – – – –

n3 Counsel's signing the compliant was not a violation of Rule 11, subject to sanctions, because the complaint was filed in state court. *Schoenberger v. Oselka,* 909 F. 2d 1086, 1087 (7th Cir. 1990). Although the district judge primarily addressed the frivolousness of the complaint, he also referred to the "arguments plaintiffs' counsel advances" and to counsel's ignoring the relevant precedent after removal to federal court, doubtless covering the frivolousness of plaintiffs' brief in opposition to the motion to dismiss. The brief was filed after removal and was a proper predicate for sanctions under Rule 11. Id., *Maciosek*, 930 F. 2d at 541-42.

– – – – – – – –End Footnotes – – – – – – – –

We must defer to the district judge's decision to award sanctions and reverse only if he abused his discretion. *Cooter & Gell v. Hartmarx Corp.*, 110 S. Ct. 2447, 2461 (1990). We agree with the district court. Mr. Kmiec's [*14] constitutional arguments and preemption arguments in the response to the motion to dismiss were frivolous. Happily he does not repeat the constitutional arguments on appeal.

Constitutional claims clearly cannot be brought against insurance companies merely because they are subject to extensive state regulation. A year before Mr. Kmiec filed the Smiths' complaint, the Eastern District of Wisconsin forcefully rejected a similar claim brought by Mr. Kmiec, *Koller v. Aetna Life Ins. Co.*, 717 F. Supp. 648 (E.D. Wis. 1988).

The above discussion of preemption adequately supports the finding that the Smiths' preemption argument was

frivolous. Furthermore, Mr. Kmiec did not mention *Pilot Life* in his brief in opposition to the defendants' motion to dismiss, let alone make a good faith argument for a modification or reversal of *Pilot Life*. Mr. Kmiec cannot argue that he was not aware of the weaknesses in his arguments or that a reasonable person would not have been aware of the weaknesses. Before the defendants filed their motion to dismiss, Delco's counsel wrote to Mr. Kmiec and advised him that his claims were frivolous and referred him to the applicable law. Delco's [*15] counsel warned that if Mr. Kmiec did not voluntarily dismiss the complaint, or at least amend the complaint to include only ERISA claims, she would request Rule 11 sanctions. Significantly, another panel of this court has recently upheld Rule 11 sanctions against Mr. Kmiec for bringing frivolous state common law claims that were preempted by ERISA. *Maciosek*, 930 F. 2d at 542. In a similar case, this court has imposed sanctions on Mr. Kmiec and his associate, Mr. McConville, finding the appeal frivolous. *Tomczyk v. Blue Cross & Blue Shield*, 951 F. 2d 771, 777-79 (7th Cir. 1991).

AMOUNTS AWARDED

Foley & Lardner, attorneys for Delco, submitted an affidavit of costs and attorney's fees totalling $8,979.32. Blue Cross and Blue Shield's in-house counsel submitted an affidavit of costs and attorney's fees totalling $8,265.00.

Mr. Kmiec filed lengthy objections, a substantial part of which reargued the question whether the award of any sanctions was appropriate. He did address many of the items claimed by defendants, in some instances stating an objection, and in some merely reciting what the charge had

been.

Judge Warren wrote a decision in which [*16] he fairly summarized the objections under 12 headings, and then dealt with them. As to arguments (1) - (3) (inappropriateness of charging for strategy sessions and general conferences between defendants), Judge Warren found them "partially persuasive" and said he applied the conclusions to disputed billings. As to argument (4), (a particular Blue Cross brief with routine citations does not merit the time billed), Judge Warren agreed and reduced the billing by half to $375.00. As to argument (5), (19.9 hours of phone conferences excessive), Judge Warren agreed and reduced by half to $995.00. As to argument (6), (excessiveness of 8 hours for an affidavit), he agreed and reduced by three-quarters, to $100.00. As to argument (8), (challenge to charge for 4.8 hours spent by senior counsel at $205.00 per hour), Judge Warren disagreed, saying that as long as the billings are reasonable, plaintiffs cannot complain that Delco chose expensive counsel. As to argument (9), (excessiveness of combined billing rate for strategy conferences), Judge Warren agreed and reduced the item by $700.00. As to argument (10), (similar to (9)), he agreed and reduced the amount by $800.00. As to argument [*17] (11), (similar to (9)), Judge Warren agreed and reduced the amount by $400.00. As to argument (12), (similar to (9)), he agreed and reduced the total by $500.00. The court awarded $6,579.32 to Delco and $6,295.00 to Blue Cross.

Mr. Kmiec did include in his statement to the district court the assertion that plaintiffs would have voluntarily dismissed the action against Delco if Delco counsel had notified him that the plan was insured. Delco counsel asserted that she could not so represent because Delco (for

some reason), wished to preserve its position that its plan was self-insured. In this court, Mr. Kmiec argues that Delco counsel failed to mitigate attorney's fees by informing him that the plan was insured, although he did not refer to a duty to mitigate in his objections in the district court.

We are not aware of Mr. Kmiec's reason for believing that he needed both defendants in the case, and why it made any difference in the outcome whether the arrangement between Blue Cross and Delco produced an insured plan or a self-insured plan. And Mr. Kmiec should have dismissed as to both defendants after the controlling authority was pointed out to him. We owe deference to the district [*18] court's computation of fees, *Cooter & Gell*, 110 S. Ct. at 2458. Judge Warren carefully considered the objections and made substantial reductions. There was no abuse of discretion.

SANCTIONS ON APPEAL

Delco and Blue Cross request that we also impose sanctions under Rule 38 of the Federal Rules of Appellate Procedure on the ground that Mr. Kmiec pursued a frivolous appeal. Sanctions are appropriate if "the appeal was prosecuted with no reasonable expectation of altering the district court's judgment and for purposes of delay or harassment or sheer obstinacy." *Reid v. United States*, 715 F. 2d 1148, 1155 (7th Cir. 1983). Although in *Maciosek*, 930 F. 2d at 542, this court decided not to award Rule 38 sanctions against Mr. Kmiec for his argument that ERISA did not preempt state common law claims, this case is distinguishable from *Maciosek*.

In this case, not only were the preemption arguments frivolous, but also the arguments concerning exhaustion of

internal plan remedies had no basis in fact. In *Maciosek*, Mr. Kmiec argued that breach of contract and tortious interference with contract claims were not preempted by ERISA, [*19] and this court recognized that it had not addressed whether ERISA preempted those specific issues. In this case, however, Mr. Kmiec argued that a bad faith claim was not preempted, although the Supreme Court considered Mississippi and not Wisconsin bad faith common law, Mr. Kmiec's attempt to distinguish the laws of the two states was frivolous. His only support for the distinction was a Wisconsin case which held that a duty of good faith does not apply to the termination of a terminable at will employee. *Brockmeyer v. Dun & Bradstreet*, 335 N.W. 2d 834, 838 (Wis. 1983). Mr. Kmiec made no attempt to prove that Wisconsin bad faith law, unlike Mississippi bad faith law, was not based on principles of tort and contract.

Mr. Kmiec's argument that the Smiths should be excused from exhausting their internal remedies was frivolous because no evidence supports this argument. At oral argument, Mr. McConville, Mr. Kmiec's associate, argued that the Smiths could not exhaust their remedies because they had not received a plan booklet which informed them what their remedies were. There is, however, [*20] no evidence that the Smiths did not have information about how to appeal the denial of their claims, and this argument was not made until the oral argument to this court. Furthermore, at oral argument, Mr. McConville seemed to claim that he still did not have a description of the review procedures, although a description of the procedure was part of the record, and the appellees included the description in a short appendix to their brief. Mr. McConville also argued that the Smiths had attempted to appeal but had received no response. All of the

communications shown in the record, however, clearly occurred before the claim was denied.

The combination of frivolous legal arguments with regard to preemption and frivolous factual arguments with regard to exhaustion appear to warrant the imposition of sanctions on Mr. Kmiec pursuant to Fed. R. App. P. 38. No reasonable attorney could have thought that this court would overturn the decision of the district court, and Mr. Kmiec's arguments are "sheer obstinacy." In conformance with Circuit Rule 38, this opinion will serve as notice to Mr. Kmiec that the court is contemplating sanctions, and we will allow him 14 days to submit a statement as [*21] to why sanctions should not be imposed in accordance with this opinion.

Accordingly, the decision of the district court is AFFIRMED.